READING ROOM

RECEIVED
JAN 3 0 1969
National Library of Medicine



Maryland State Medical Journal

OFFICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

VOLUME 18. NUMBER 1
JANUARY 1969

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

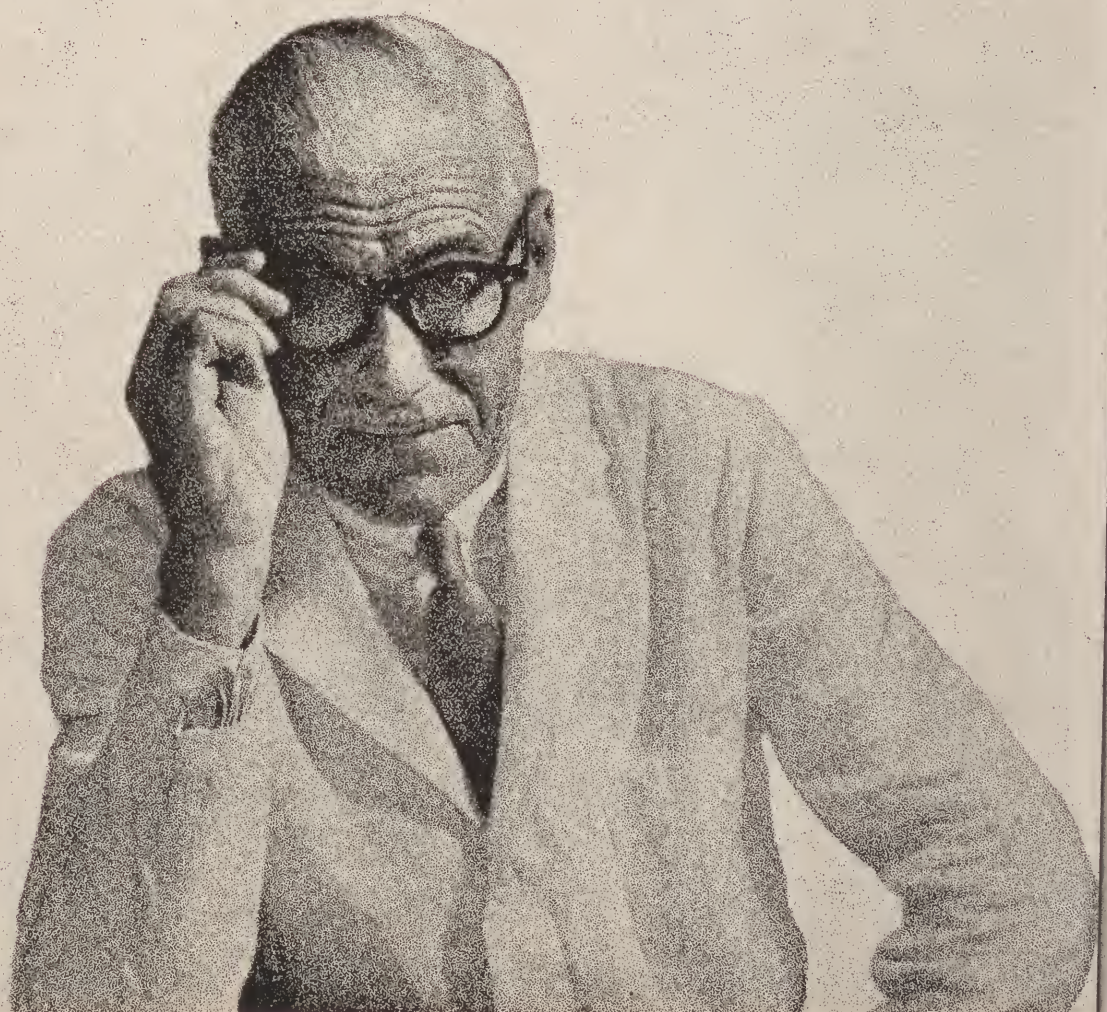
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®

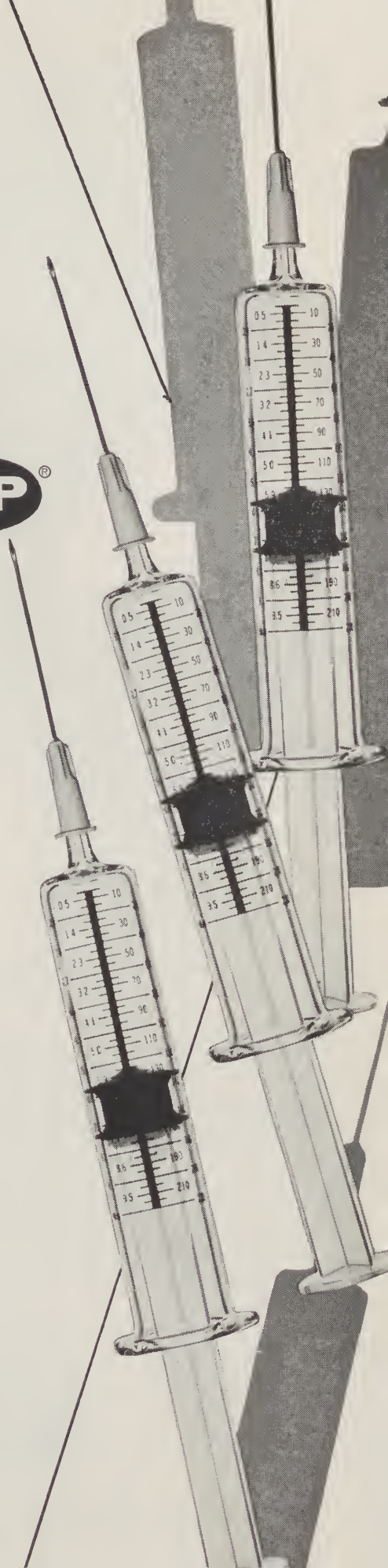


BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

(BSP03)

BALTIMORE, MARYLAND 21201

Maryland State Medical Journal

VOLUME 18 JANUARY 1969 NUMBER 1

EDITOR

C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD

E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, MD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

CONTENTS:

Adolescence: A Prominent "Disease" of the '60s 50

Emotional Problems of Adolescence, Kurt Glaser, MD 51

Medical Problems of the Adolescent, Matthew Debuskey, MD 55

A Comprehensive Approach to Obstetrical Problems of Adolescence, Herbert L. Yousem, MD, Leon Gordis, MD 60

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 63

Ethics Corner—Use of Credit Cards 64

Traffic Safety—Doctor, Do You Ever Discuss Driving With Your Patients? Irene L. Hitchman, MD 65

Maryland State Department of Mental Hygiene—Maryland's Privately Operated Psychiatric Hospitals 68

Rehabilitation Notes—Prediction of Performance of Patients with Hip Fracture 69

Pathology—Innovations in Blood Procurement 79

Maryland State Department of Health—Highlights 81

Heart Page—Cardiac Amyloidosis, Werner F. Barth, MD 83

Tuberculosis—Smoking, Sputum, and Lung Cancer 85

Baltimore City Health Department—Malnutrition in Baltimore's Children 89

Library Page—A Guide: To Help You Find Your Way Around 91

Alcoholism Section—A Physician Considers His Responsibility for Treating Alcoholics, Richard H. Anderson, MD 103

Doctors Take Note **5** Executive Secretary's Newsletter **9** Insight into Escalating Hospital Costs **14** AMA: Better Business Bureau **17** Annual Meeting Information **25** MEDIC **27** Book Reviews **30** The Month in Washington **33** Woman's Auxiliary **36** Medical News **37** When Should a Physician Assist a Surgeon? **49** Accessions to the Library **91** Four Million Diabetics Here—1.6 Million Don't Know It **94** Expansion at the University of Maryland **109** Component Societies **111** Classified Advertising **114** Advertising Index **114** Index to Vol. 17, January-December 1968 **115**

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland.

Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

OFFICERS OF
THE MEDICAL AND CHIRURGICAL SOCIETY

President: Arthur G. Siwinski, MD
President elect: Russell S. Fisher, MD
First Vice President: Henry A. Briele, MD
Second Vice President: Wolcott L. Etienne, D
Third Vice President: George O. Eaton, M
Secretary: William A. Pillsbury, MD
Treasurer: Karl F. Mech, MD

COUNCILORS

Western District

Archie R. Cohen, MD—1969
Henry V. Chase, MD—1969

Central District

Robert C. Kimberly, MD—1969
William Carl Ebeling, MD—1970
John Collins Harvey, MD—1970
John F. Schaefer, MD—1970
William G. Speed, III, MD—1970
J. Arthur Weinberg, MD—1970
John T. Chissell, MD—1971
John M. Dennis, MD—1971
J. Morris Reese, MD—1971
Harry M. Robinson, Jr., MD—1971
Donald J. Roop, MD—1971

Eastern District

Arthur T. Keefe, MD—1970
Raymond M. Yow, MD—1971

Southern District

Manning W. Alden, MD—1969
J. Parran Jarboe, MD—1971

South Central District

William B. Hagan, MD—1969
Henry P. Laughlin, MD—1970
John G. Ball, MD—1971
Wolcott L. Etienne, MD—1971
Seruch T. Kimble, MD—1971

Terms of office expire at conclusion of annual meeting

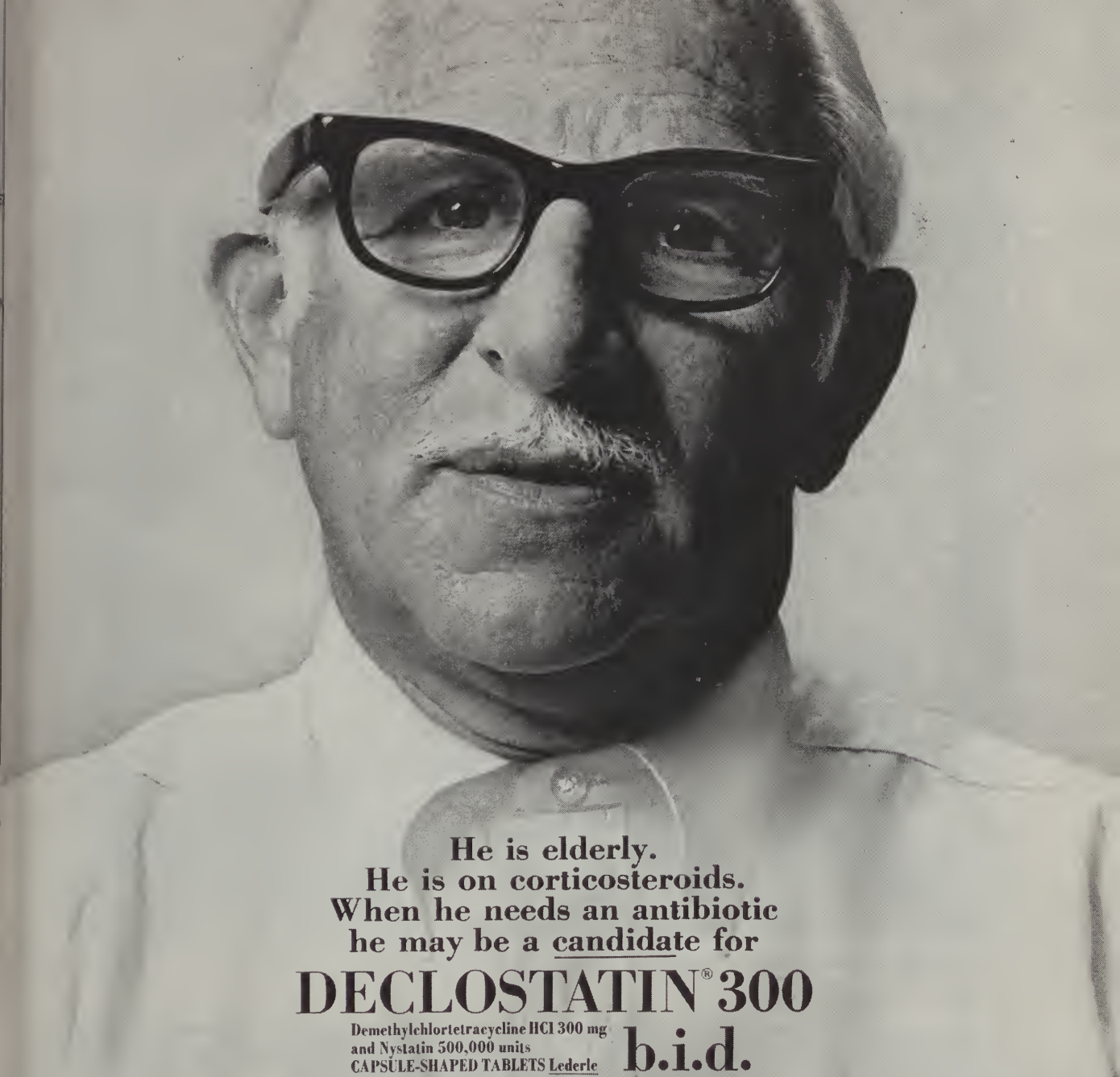
DELEGATES TO THE
AMERICAN MEDICAL ASSOCIATION

Russell S. Fisher, MD—1969
J. Sheldon Eastland, MD—1970
Robert vL. Campbell, MD—1971

ALTERNATES:

M. McKendree Boyer, MD—1969
Robert C. Kimberly—1970
Charles F. O'Donnell, MD—1971

Terms of office expire at end of calendar ye



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

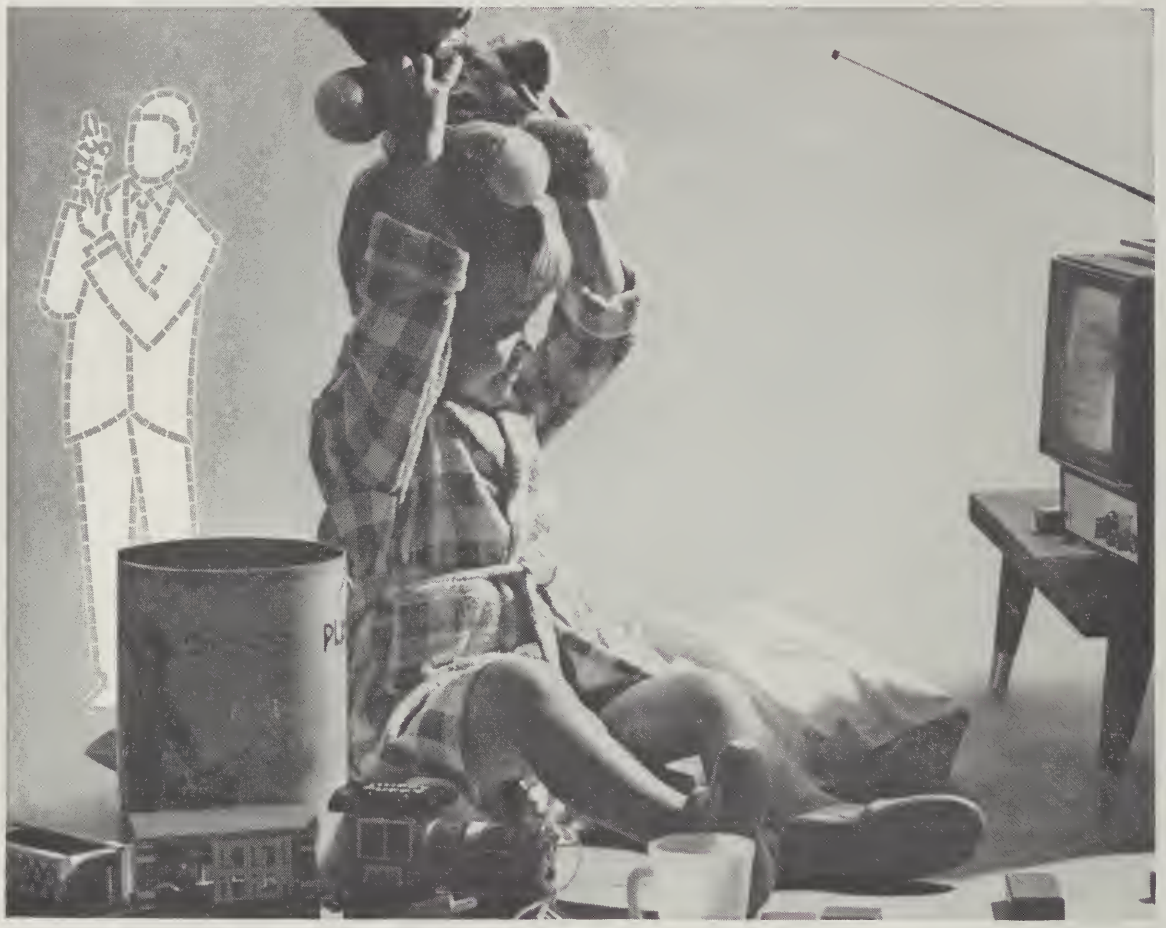
Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

Doctors take note...

JANUARY 30-31, 1969
NATIONAL BUREAU OF STANDARDS

Symposium—Ion-Selective Electrodes: National Bureau of Standards, Gaithersburg, Md. Ten papers on theory, methodology, characteristics and applications of electrochemical sensors, and a panel discussion will be presented. Chairman: Dr. Richard A. Durst. Contact: Dr. Durst, Room B326, Chemistry Building, National Bureau of Standards, Washington, D.C. 20234. Telephone: (301) 921-2860.

JANUARY 30-31, 1969
NATIONAL LEAGUE FOR NURSING

National Invitational Conference—Comprehensive Services in Long Term Care: Hotel Commodore, New York City. Newest techniques in physical and psychological rehabilitation, and the multidisciplinary approach to health care will be discussed. Director: Mrs. Ethel Saunders. Contact: Sara W. Kelley, National League for Nursing, 10 Columbus Circle, New York, N.Y. 10019. Telephone: (212) JU 2-1022, ext. 832.

FEBRUARY 3, 1969
MARYLAND HEART ASSOCIATION

Affiliate and Division Staff Meeting: 9:30 A.M., Board Room, 415 N. Charles St., Baltimore, Md. 21201.

FEBRUARY 4, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conference—Neurogenic Disturbances of Bladder Function: 4 P.M., Psychiatric Institute, Room I-704, University of Maryland Hospital, Baltimore, Md.

FEBRUARY 6-11, 1969
AMA COUNCIL ON MEDICAL EDUCATION

65th Annual Congress: Palmer House, Chicago, Ill. Contact: Secretary, Council on Medical Education, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

FEBRUARY 13-14, 1969
HEART ASSOCIATION OF SOUTHEASTERN PENNSYLVANIA

8th National Symposium—Pulmonary Circulation: Sheraton Hotel, Philadelphia, Pa. Chairman: William J. Rashkind, MD. Contact: John C. Nolan, Heart Association of Southeastern Pennsylvania, 318 S. 19th St., Philadelphia, Pa. 19103.

FEBRUARY 18, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conference—Pheochromocytoma: 4 P.M., Psychiatric Institute, Room I-704, University of Maryland Hospital, Baltimore, Md.

FEBRUARY 19, 1969
MARYLAND KIDNEY FOUNDATION

Seminar—Aldosterone and the Clinician: 5 P.M., University of Maryland Hospital, Psychiatric Institute, Room I-704, Baltimore, Md. Speaker: David P. Lauler, MD, Director, Endocrine-Metabolic Unit, Peter Bent Brigham Hospital.

FEBRUARY 19-22, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Advances in Infectious Disease and Immunology: Baylor University College of Medicine, Houston, Texas. Director: Vernon Knight, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 13-15, 1969
AMERICAN ELECTROENCEPHALOGRAPHIC SOCIETY/BAYLOR UNIVERSITY COLLEGE OF MEDICINE

Postgraduate Course—Current Problems in Electroencephalography: Advances Toward Their Solution: Baylor University College of Medicine, Houston, Texas. Contact: Dr. Peter Kellaway, Baylor University College of Medicine, Texas Medical Center, Houston, Texas 77025.

MARCH 13-15, 1969
AMERICAN MEDICAL ASSOCIATION/AMERICAN BAR ASSOCIATION

1969 National Medicolegal Symposium: Caesar's Palace, Las Vegas, Nevada. Contact: American Bar Association Division of Legal Practice and Education, 1155 E. 60th St., Chicago, Ill. 60637.

MARCH 4, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conference—Drug Therapy of Hypertension: 4 P.M., Psychiatric Institute, Room I-704, University of Maryland Hospital, Baltimore, Md.

MED-CHI ANNUAL MEETING

APRIL 9, 10, 11

For information on the happenings,

see pages 25 anb 26.



WHEN YOUR PATIENTS NEED NURSING CARE

Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED

24 HOUR SERVICE ESTABLISHED 1935

BALTIMORE, MARYLAND 21229

Save at Baltimore Federal

where
quarterly
dividends
give you
that
warm
comfortable
feeling



Open or add to your insured passbook savings account by the 10th and earn Baltimore Federal Savings & Loan Association's extra-high quarterly dividends for the whole month.

Downtown at Fayette & St. Paul Sts. • Eastpoint Shopping Center • Reisterstown Road Plaza
Towson at 7 Alleghany Ave. • Carney at 9609 Harford Road above Joppa • Yorktowne Plaza
Downtown Westminster at 6 East Main Street.



Mano Swartz

JANUARY CLEARANCE SALE!

Buy Now and Save

Maryland's Exclusive Representative for *Oleg Cassini* FURS

FURS WITH THE LABEL THAT LEAVES NO DOUBT

Maryland's Oldest and Largest Furrier

225 N. HOWARD ST.
BALTIMORE

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.

We Also Repair Jewelry

In our own shop, the same skilled craftsmen who create our fine jewelry also do the repairs.

For this type of work you will find our prices in line—even less in many instances.

If a stone needs to be re-set, if a pin is broken, if a ring is to be made larger or smaller—these jobs are just as welcome as an elaborate re-mount. Feel free to consult us.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

CAMP TRADE MARK *announces*

a new development in

BRACES



NEW TAYLOR BRACE—designed for comfort, appearance, and effective spinal splinting. Handsome washable slip-on cover helps hold rigid metal back brace firmly in position; also forms part of a body-encircling white jacquard corset. Convenient front closing, with five alternating pull straps for precise adjustment.

DONALD O. FEDDER, ORTHOTIST

Rents and Sells Hospital Equipment

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

executive secretary's newsletter

January, 1969

1969 DUES BILLS IN MAIL

1969 Dues bills have been mailed to all members and are payable before JANUARY 31, 1969, in order to be eligible for legal defense in the event of suit being filed.

Legal defense includes the provision of a panel of expert medical witnesses to evaluate the merits of the case; as well as having these witnesses available to testify in court, if needed. Legal counsel is also provided and paid from Faculty funds.

The Council of the Faculty has ruled that strict interpretation of the bylaws must be followed. Late payment of dues precludes provision of this membership benefit.

DOCTORS OF OSTEOPATHY LICENSED

A total of 15 Doctors of Osteopathy have been licensed to practice medicine and surgery in Maryland. Professional association with these individuals is permissible, provided the cultist aspects of Osteopathy have been abandoned by those involved.

Those so licensed are: Drs. Christopher L. Ginn, John M. Gustin, Joseph W. Lindstrom, Richard C. MacDonald, Bertram H. Waskey, Millard Bass, all of Baltimore; Laurence R. Bower, Silver Spring; Murray Goldstein, Bethesda; Chester L. Bailey, Kensington; Robert B. Liskey and Robert C. Snavely, Hagerstown; Joseph C. Snyder, Bozman; Basil Tully, Chestertown; Ernest R. MacDonald, Annapolis; and Victor F. Brennan, Glen Burnie.

PUBLIC SPEAKING COURSE

A one-day public speaking course will be held under the auspices of the Public Relations Committee of the Faculty on Thursday, March 13, 1969, from 9:00 a.m. to 5:00 p.m. Registration is limited and those interested should contact the Faculty office promptly to indicate their wish to attend.

GRANTS AVAILABLE

Grants now available include a Fellowship in Business-Government Relations at the American University's School of Business Administration, Washington, D.C. The American Medical Political Action Committee will

GRANTS AVAILABLE (cont'd)

provide a graduate scholarship in the amount of $4,500 to anyone working toward a masters or PhD degree.

The Maryland Chapter, American Cancer Society, has available travel grants for physicians to acquire particular skills with respect to research, specific diagnostic techniques or specific therapy as related to neoplastic disease. The travel fellowship can provide transportation and room and board to those physicians who due to budgetary restrictions, find travel money unavailable for this type of study. The grant applicant must be a medical educator at a recognized teaching institution or community hospital in Maryland.

REFERENCE COMMITTEE MEETING

The Reference Committee meeting date has been set for

THURSDAY, MARCH 20, 1969

at 8:00 p.m., in the Faculty building, at which time any resolutions for consideration by the Annual Session of the House of Delegates will be discussed. All members in good standing are invited to attend this session.

CONGRESS ON SOCIOECONOMICS OF HEALTH CARE

The third national Congress on the Socioeconomics of Health Care has been scheduled for March 28 and 29, at the Palmer House, Chicago, Illinois. Full details may be obtained from the AMA or the Faculty office.

MED-CHI RETIREMENT FUND

The net asset value of the Med-Chi Members Retirement Fund has increased 15.28 % for the period January 1, 1968, through October 31, 1968.

MEDICAL SCHOOL INCREASE

The Carnegie Commission on Higher Education has called for new and expanded facilities to increase the supply of medical students by 75% by 1976.

The proposal calls for Federal grants to cover the entire cost of creation of the new places, as well as start-up grants to build about 20 new medical schools, at a rate of four to five per year for five years. Grants to students, depending on need, will be as much as $3,500 per year; in addition to grants per student to the institutions.

John Sargeant

Executive Secretary

IT MAY BE LATER THAN YOU THINK . . .

DOCTOR

BUT NOT TOO LATE TO ARRANGE

ACCURATE AND COMPLETE BUSINESS AND FINANCIAL RECORDS TO PROPERLY SUPPORT YOUR TAX RETURNS

◆

CAN YOU AFFORD LESS

?

"PM SYSTEM"

COMPLEMENTS

AUTOMATED BILLING

AND

OFFERS YOU

MAXIMUM CONTROL AND SAFETY FROM BALANCING RECORDS AND MINIMUM EFFORT ON YOUR PART

◆

DIAL 752-5920

Professional Management Co.

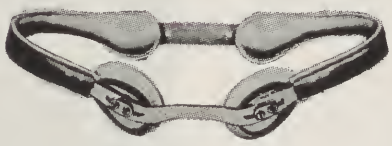
914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT THE BEST AIDE KNOWN

All the newest, improved

SURGICAL APPLIANCES



- Arch Supports
- Cervical Collars
- Abdominal Supports
- Sacro-Lumbar Belts
- Colostomy and Urinary Appliance

COMPETENT, EXPERIENCED SURGICAL FITTERS TO ASSIST YOU

WE RENT and SELL

- WHEEL CHAIRS
- HOSPITAL BEDS
- INVALID LIFTERS
- PUMPS . . . LAMPS

MEDICARE FORMS

We will assist your patients in processing the required Medicare information concerning items purchased or rented from us.



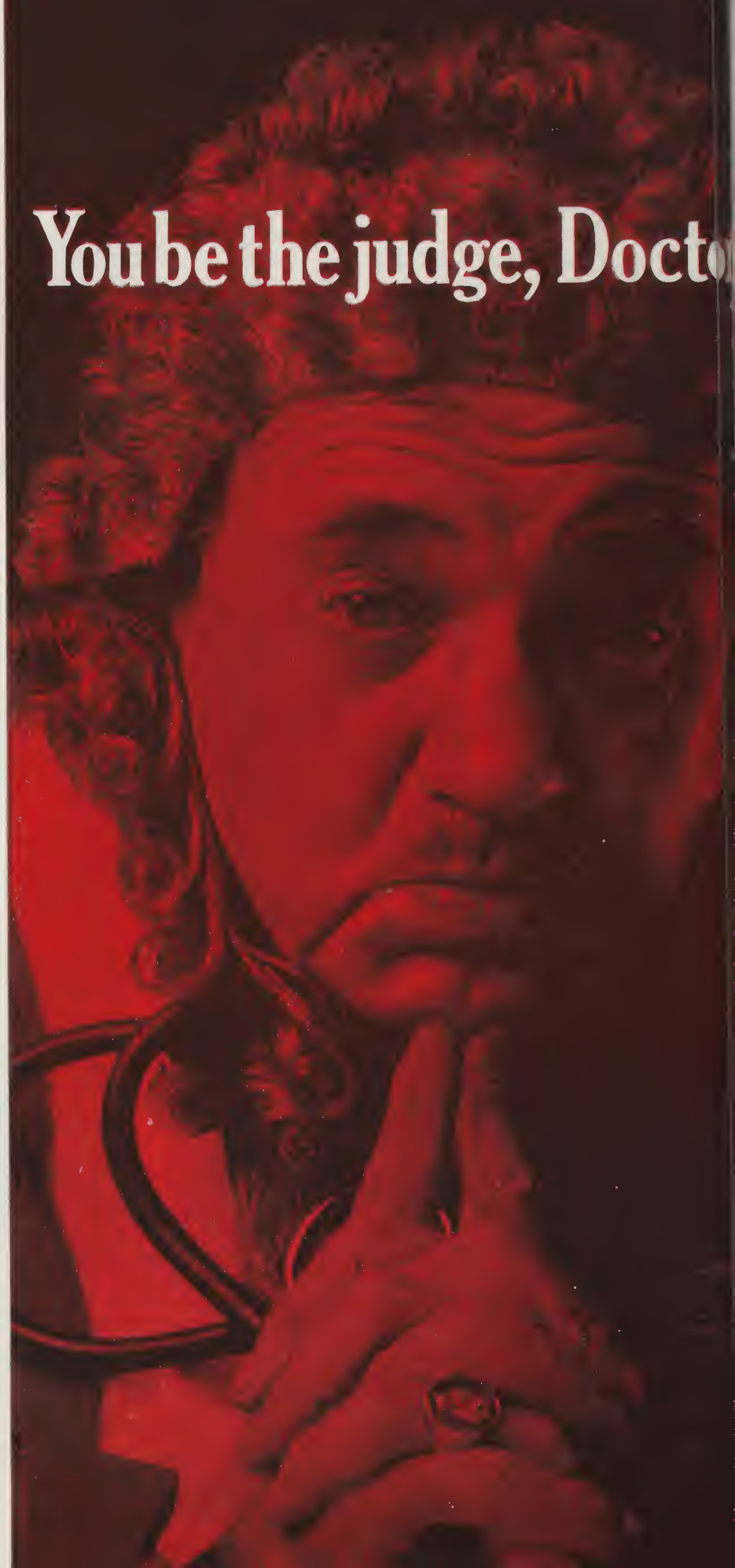
Serving the Medical Profession for almost half a century

Murray-Baumgartner

SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.

Phone: 669-9300 **Baltimore, Md. 21216**



Summation:
In addition to its primary indications for duodenal and gastric ulcer, Robinul Forte (glycopyrrolate) is indicated for other G-I conditions that may benefit from anticholinergic therapy. Robinul-PH Forte (glycopyrrolate 2 mg. with phenobarbital) is indicated when these situations are complicated by mild anxiety and tension.

Contraindications: Glaucoma, urinary bladder neck obstruction, pyloric obstruction, stenosis with significant gastric retention, prostatic hypertrophy, duodenal obstruction, cardiospasm (megaesophagus), and achalasia of the esophagus, and in the case of Robinul-PH Forte, sensitivity to phenobarbital.

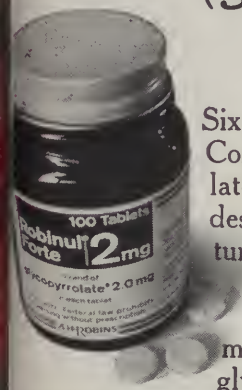
Precautions: Administer with caution in the presence of incipient glaucoma.

Adverse Reactions: Dryness of the mouth, blurred vision, urinary difficulties, and constipation are rarely troublesome and may generally be controlled by reduction of dosage. Other side effects associated with the use of anticholinergic drugs include tachycardia, palpitation, dilatation of the pupil, increased ocular tension, weakness, nausea, vomiting, headache, dizziness, drowsiness, and rash.

Dosage: Should be adjusted according to individual patient response. Average and maximum recommended dose is 1 tablet three times a day; in the a.m., early p.m., and at bedtime. See product literature for full prescribing information. Supply: Robinul (glycopyrrolate 1 mg.): Robinul Forte (glycopyrrolate 2 mg.); Robinul-PH (glycopyrrolate 1 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming); Robinul-PH Forte (glycopyrrolate 2 mg.) with phenobarbital 16.2 mg. (Warning: may be habit forming), in bottles of 100 and 500 tablets. A. H. Robins Company, Richmond, Va. 23220.

A·H·ROBINS

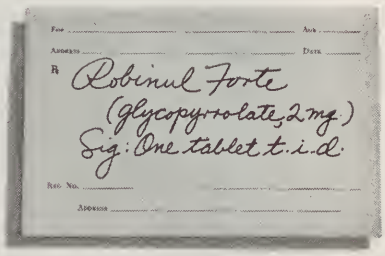
In peptic ulcer therapy, won't you give Robinul® Forte a Fair Trial?
(glycopyrrolate)



Six years ago the A. H. Robins Company introduced glycopyrrolate, a unique anticholinergic agent described in the prescribing literature as more closely approaching the ideal compound for controlling gastric hyperacidity and hypermotility of the G-I tract. Although glycopyrrolate (Robinul Forte) found good acceptance among numerous physicians, many others just didn't seem to want to give it a try, probably because the anticholinergic they were already using was giving acceptable results.

However, we believe you'll agree there's always room for a better anticholinergic. This is why we're asking you to give Robinul Forte a fair trial. Robinul Forte exerts a highly specific antisecretory action and marked inhibitory effect on intestinal tone. We're convinced you'll agree that this is indeed an outstanding drug when you observe its outstanding suppression of ulcer symptoms. Furthermore, it is unique in that it reduces intestinal tone, yet has little or no effect on peristalsis. In addition, the incidence of the more bothersome peripheral side effects is low.

No longer does the physician have to look for extreme dry mouth as the measure of his anticholinergic's effectiveness. The only way we can demonstrate to you firsthand the efficacy of glycopyrrolate (Robinul Forte) is for you to try it in your practice. That's why we're asking you to give it a Fair Trial. How can you give it a Fair Trial? You do it this way:



First: When you see your very next ulcer patient, write him a script as shown.

Next: Wait 10 days or until your patient comes in for his next appointment and get his "verdict" as to how he feels. Examine all the evidence and make your evaluation of his condition.



Finally: Render **your** verdict. If it's "significant improvement and marked relief of symptoms," then we believe you'll agree that Robinul Forte has proved its worth, and we rest our case. If not, consider our case for Robinul Forte closed. That's a Fair Trial, Doctor, and it's all we ask.

Robinul® Forte
(glycopyrrolate, 2 mg.)

The summation is an important part of every case. You'll find ours on the preceding page, Doctor.

Insight into Escalating Hospital Costs

Employee dishonesty, waste and indifference constitute an ever increasing portion of the rise in hospital costs, the president of a New York based consulting firm reported during last year.

Some of the aforementioned problems, frequently overlooked by the hospital administrator, revealed in a nationwide study are startling.

For example, losses due to employee theft have more than doubled in the last three years; supervisors, technicians and professional personnel are increasingly, and more significantly, involved in dishonesty and manipulations; the most costly, and yet most difficult defalcations for management to detect, are those occurring in purchasing, cashiering, pharmacy and central supply. Equally harmful are losses of supplies and material experienced in maintenance, dietary and laundry departments. Also noteworthy is the conflict of interest that emanates from laboratory and radiology services, and from research projects.

Another fact revealed in the study is that recent wage increases of historic dimensions have resulted in only marginal productivity gains.

The opportunities for theft, waste, collusion and all imaginable forms of malpractice in this more than 8 billion dollar a year industry stagger the imagination. Theft in supplies, equipment, food, drugs, narcotics and expendable goods intended for patients has become commonplace.

Recognizing there are probably no more dedicated and harder working executives with a more vital degree of responsibility than hospital administrators, the survey continued, hospital costs, nevertheless, have increased 51.8% in the past three years, and will continue to increase in view of the hospital's ever expanding role in community affairs.

"The best untapped avenue of expense reduction and improved productivity is preventive management," the report stated. "By focusing on inventory losses and personnel performance, executives get to the heart of their problems. In addition to employee dishonesty, administrators uncover systems breakdowns, supervisory failures, rank and file inefficiencies, nursing shortcomings and poor employee morale—all causes of rising costs and patient neglect."

The need to know what is really going on beneath the surface is highlighted when management engineers undertake performance audits, systems surveys and inventory control projects. In more than 50% of these cases, with no prior indication that dishonesty existed, fraud, inventory manipulations, falsifications of records, kickbacks and other forms of dishonesty have been uncovered. Obviously, management cannot make a sensible decision merely by studying comparative statistics concerning past performance.

Adequate controls neither end nor begin with the locking of doors, issuing passes, uniformed guards, or even firing a dishonest employee accidentally caught. The problem instead is really one of human relations and human behavior. "It may be more difficult to read the subtle barometer of employee behavior than to interpret a profit and loss statement, but the one requires as much scrutiny and concern as the other.

"Only when management learns what is really going on can it take corrective action and establish an atmosphere showing that management is alert and cares. When indifference and dishonesty run rampant, top executives are at fault if they tolerate it, and in danger if they do not control it."



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



DOCTORS' OFFICES

LARGE
MEDIUM
SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST. CORPORATION

11 E. Chase St.

Phone 539-8553

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ **INGLESIDE SHOPPING CENTER**

5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)

PHONE: 747-1237

★ **HILLENDALE SHOPPING CENTER**

6867 LOCH RAVEN BLVD. (Beltway Exit 29)

PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.



Prompt, professional service 24 hours a day, every day! A complete line of hospital beds, wheelchairs, traction equipment, oxygen, crutches, walkers, commodes, lamps, whirlpools—everything to help patients get well faster.

We Process MEDICARE Equipment Claims.

358-3400

6316 Reisterstown Road
Baltimore

Brentwood Inn

FRENCH CONTINENTAL CUISINE

Smorgasbord Luncheon and Dinner every Tuesday . . . . .

"Home of Maryland's Internationally Famous Wine Cellar" . . . .

We honor all preferred Credit Cards

● ***NEW!*** Another Dining Room has been added to accommodate our many guests ●

OPEN DAILY & SUNDAY 11 A.M. to 2 A.M.

Fifth Ave. & Brentwood—1 block N. E. of Dundalk and Holabird Ave. 1 mile from Holabird Ave. Exit of Baltimore Harbor Tunnel

We cater to Private Parties, Banquets and Dinners

AT. 5-0520 *Ample Free Parking* **BALTIMORE, MD. 21222**

AMA, Better Business Bureau: Decade Of Cooperatively Combating Quackery

From the snake oils, elixirs, and nostrums of the past, health quacks have moved to more sophisticated pseudomedications, often more powerful and more dangerous, the president of the National Better Business Bureau said recently.

"What was once 'magnetic' or 'galvanic' is now 'electronic' or 'radioactive,' and what was once touted as a new 'natural' discovery is now promoted as a new 'laboratory' discovery," Richard Maxwell told the Fourth National Congress on Health Quackery, meeting at the Drake Hotel.

Mr. Maxwell, a business executive before assuming the NBBB position in New York in June, told the American Medical Association-National Health Council conference:

"According to some reports, quackery today brings in close to a billion dollars annually to its practitioners. Our modern medical quacks are quite aware of legal loopholes and are often fortified by dubious 'clinical support' for their claims."

A decade ago, Mr. Maxwell pointed out, a special program for correcting deceptive or misleading advertising in the health field was instituted with the aid and support of the American Medical Association, other professional groups, and private industry.

"We, therefore, celebrate today ten years of fruitful cooperation with the American Medical Association, a great organization for its profession and one which has supported us with funds and professional counsel," he said.

In recent years the annual volume of complaints and inquiries has ranged between 5,000 and 6,000 at the National Better Business Bureau alone.

"The bulk of complaints involves a relatively small number of products, principally vitamin-mineral compounds, weight controllers, devices for massage, hair removal, mechanical aids for hernias, and hearing devices.

"Within the last year, the problems associated with wigs and wiglets, garments claimed to be weight-reducing aids, smoking deterrents, and a new crop of wrinkle-removing cosmetics, have occupied our time.

"The proportion of complaints received by the Bureau doubtless understates their magnitude generally because many are handled directly or through local bureaus. Moreover, experience suggests that dissatisfaction with products and methods of a personal variety, such as rejuvenators, hair and scalp treatments, remedies for 'female troubles,' and for certain emotional or mental problems, and professional services, often do not result in letters of complaint."

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery

MU 5-3232

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202

STERLING LIGHTING CO.

DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY



We Repair and make Lamps
"Lamps make the home Beautiful"
LE 9-0222
403 N. Charles Street
Baltimore, Md. 21201

This is the new 144S Volvo Sedan For 1969



What a prescription for "Same-old-car-itis."

Volvo offers the most advanced safety features of any car. It's so economical it gets over 25 m.p.g. With automatic transmission, stereo tape, air conditioning available—and world famous Volvo quality built-in, we think you'll agree the prognosis is extremely favorable.

FREE 24 HOUR DEMONSTRATION

michaelson motors, inc

America's Largest Volvo Dealer

5801 REISTERSTOWN RD. Open Nitely 'til 9:30 FO 7-4700

INSECTS . . . TERMITES . . . RODENTS

"Call the Rose Man" Phone: 467-5300

ROSE EXTERMINATOR CO.

"Call the Rose Man"

OVER 100 YEARS

3950 Falls Road, Baltimore, Md. 21211

F.H.A. INSPECTIONS — PRETREATMENTS

Prompt—Discreet—Efficient

SERVICE

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

CHARLES W. NEVILLE, JR., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—253-2761

See next page for prescribing informati



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specifi in acute otitis medi

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, m most common invaders. In otitis media, where is difficult to isolate the causative organism, th coverage may be important. However, some str may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged ac permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enteroc ti pruritus ani. Skin—maculopapular and erythematous rashes; aa case of exfoliative dermatitis has been reported. Photosensiti onycholysis and discoloration of the nails (rare). Kidney—rise in U apparently dose-related. Transient increase in urinary output, sm times accompanied by thirst (rare). Hypersensitivity reactions—ri caria, angioneurotic edema, anaphylaxis. Teeth—dental staining ye low-brown) in children of mothers given this drug during the latte na of pregnancy, and in children given the drug during the neonatal pe od, infancy and early childhood. Enamel hypoplasia has been se a few children. If adverse reaction or idiosyncrasy occurs, discon u medication and institute appropriate therapy. Demethylchlort ra cycline may form a stable calcium complex in any bone-forming t su with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Sh u be given 1 hour before or 2 hours after meals, since absorpti impaired by the concomitant administration of high calcium co drugs, foods and some dairy products. Treatment of streptoc infections should continue for 10 days, even though symptoms subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, mg, 150 mg and 75 mg of demethylchlort cycline HCl.

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

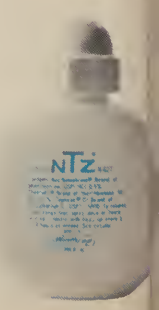
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop



"With this diet you can eat anything you like, here's a list of the things you like!"

OBETROL® for weight control

Each OBETROL-10 tablet contains: Methamphetamine Saccharate 2.5 mg.; Methamphetamine Hydrochloride 2.5 mg.; Amphetamine Sulfate 2.5 mg.; Dextro-amphetamine Sulfate 2.5 mg.; (OBETROL-20 tablets contain twice this potency) Pat. #2748052.

This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperractive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

Dosage and Administration: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100. 500, and 1000.

REQUEST SAMPLES AND LITERATURE

OBETROL PHARMACEUTICALS • BROOKLYN, N.Y. 11207

DR. _____

ADDRESS _____

CITY _____ STATE _____

SIGNATURE _____

OBETROL PHARMACEUTICALS
Div. of Rexar Pharmacal Corp., Brooklyn, N.Y. 11207

MEDICAL AND CHIRURGICAL FACULTY

OF THE STATE OF MARYLAND



MED-CHI

Members Retirement Plan

TRUSTEE AND ADMINISTRATOR

Mercantile-Safe Deposit and Trust Company

INVESTMENT ADVISOR

T. Rowe Price and Associates, Inc.

LIFE UNDERWRITER

Shenandoah Life Insurance Company

FOR MORE INFORMATION DETACH AND MAIL SLIP DIRECTLY TO:

MED-CHI MEMBERS
RETIREMENT PLAN
1211 Cathedral Street
Baltimore, Maryland 21201

Name .....

Address .....

City ..... State ..... Zip Code .....

Telephone Number ..... Date of Birth .....
(month) (day) (year)

171st Annual Meeting

More prominent speakers* who will present papers during the Annual Meeting in April include Milton Helpern, MD, and Joseph Lee Hollander, MD.

Official investigation of *Sudden, Suspicious and Violent Deaths: A Community Responsibility,* is the title of the presentation by **Milton Helpern, MD,** to be given during the scientific sessions at Annual Meeting.



Dr. Helpern

At present, Dr. Helpern is Chief Medical Examiner of the City of New York; Professor and Chairman of the Department of Forensic Medicine at the New York University School of Medicine, and Lecturer in Legal Medicine and Visiting Professor of Pathology at Cornell University Medical College.

Dr. Helpern, who was born and educated in New York City, received his medical degree from Cornell University Medical College. In 1929 he was elected a diplomate of the National Board of Medical Examiners, and his specialty board certifications include the American Boards of Pathology, Pathologic Anatomy, and Forensic Pathology. He is a consultant in pathology and forensic pathology at the Armed Forces Institute of Pathology, the Bureau of Medicine of the Food and Drug Administration, the Criminal Justice Coordinating Council of New York City, as well as several other agencies and various hospitals.

He is past president of numerous medical societies and is president of the Alumni Association of Cornell University Medical College, the International Association of Accident and Traffic Medicine and the National Association of Medical Examiners. His honorary memberships include both national and international organizations. Dr. Helpern is co-author of *Legal Medicine, Pathology and Toxicology,* and author of approximately 60 articles on medical-legal subjects. Currently, he is involved in several research projects.

Joseph Lee Hollander, MD, will speak on *Intrasynovial Corticosteroid Therapy in Arthritis* in April.



Dr. Hollander

Born in Ferguson, Missouri, Dr. Hollander obtained his secondary education there. He received his AB from Cornell University, and in 1935 he was awarded his MD from the University of Pennsylvania School of Medicine. Dr. Hollander served both his internship and residency at the Pennsylvania Hospital in Philadelphia, where he directed an arthritis clinic until he entered the armed forces in 1942. After his discharge in 1946, he became a member of the faculty of the University of Pennsylvania School of Medicine and was appointed Professor of Medicine in 1962. He has been Chief of the Arthritis Section at the University Hospital since 1946.

Dr. Hollander has been Editor-in-Chief of *Arthritis and Allied Conditions* since 1948, and his research group has pioneered in joint physiology, intra-articular corticosteroid injections, synovial fluid analysis, and the immunopathogenesis of rheumatoid arthritis.

He is a past president of the American Rheumatism Association and is an honorary member of many international rheumatism societies.

* See the December Journal for capsule biographies of **Robert L. Evans, MD,** and **Howard W. Jones, Jr., MD,** who also will be featured during the scientific sessions of Annual Meeting in April.

Annual Meeting—Baltimore
Medical and Chirurgical Faculty

WEDNESDAY, APRIL 9

The Alcazar

9:30 AM Meeting of the House of Delegates
2:00 to 5:00 PM Scientific Sessions

The Belvedere Hotel

6:00 to 7:30 PM Hospitality Night for all members of the Faculty

The Alcazar

8:30 PM Medicolegal Symposium

THURSDAY, APRIL 10

The Alcazar

9:30 AM Scientific Sessions

The Belvedere Hotel

12:30 PM Annual Luncheon

The Alcazar

2:15 PM Scientific Sessions

The Belvedere Hotel

6:15 PM Annual Presidential Reception and Banquet

FRIDAY, APRIL 11

The Alcazar

9:30 AM Scientific Sessions

The Faculty Building (1211 Cathedral Street)

2:00 PM Meeting of the House of Delegates

On SATURDAY MORNING, APRIL 12, all physicians are invited to attend the medical and pediatric grand rounds in the new Turner Auditorium at The Johns Hopkins University Hospital and School of Medicine.

Get the Most From the Annual Meeting
Attend the Scientific Sessions and Social Functions
See the Scientific and Technical Exhibits at the Alcazar



MEDIC 1969 SCHEDULE

OF POSTGRADUATE PROGRAMS

presented through

Medical Education's Dedicated Instructional Channel

Supported in part by The Medical and Chirurgical Faculty and a grant from Merck, Sharp and Dohme.

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Prince George's General, Cheverly
Provident, Baltimore
Rosewood State, Owings Mills
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
South Baltimore General, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Washington County, Hagerstown

Other Locations:

Medical and Chirurgical Faculty, Baltimore
State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
539-0872

or

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201 383-3010 Ext. 8722

JANUARY 31, 1969—12:30 P.M.

IRON DEFICIENCY

C. Lockard Conley, MD
Professor of Medicine
The Johns Hopkins University School of Medicine

The causes, manifestations and clinical implications of iron deficiency will be discussed and illustrated by representative cases. Emphasis will be placed on differential diagnosis and treatment. Discussion will include the economical and appropriate use of laboratory tests and their interpretation.

Sponsor: Greater Baltimore Medical Center
Replays: Monday, February 3, 1969 12:30 P.M.
Wednesday, February 5, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

FEBRUARY 7, 1969—12:30 P.M.

CONSTRICTIVE AND RESTRICTIVE HEART DISEASE

Kenneth B. Lewis, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine, and
Assistant Chief of Medicine,
Baltimore City Hospitals

This discussion will review briefly the typical presentation of patients with constrictive pericardial disease and will then emphasize several unusual ways in which this entity may be present. The difficulty in separating, on clinical examination and even at times on laboratory evidence, constrictive pericardial disease for which surgical therapy offers chance for improvement from restrictive myocardial disease for which there is no specific treatment will be discussed. The current diagnostic methods for evaluating patients suspected of having this form of heart disease will be reviewed.

Sponsor: Easton Memorial Hospital
Replays: Monday, February 10, 1969 12:30 P.M.
Wednesday, February 12, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

FEBRUARY 14, 1969—12:30 P.M.

VENOUS VASCULAR DISEASE

J. Alex Haller, Jr., MD
Associate Professor of Pediatric Surgery
The Johns Hopkins University School of Medicine

This talk will be on the pathophysiology and management of deep thrombophlebitis and will include the treatment of thromboembolism, massive venous occlusion, and the post-phlebitic limb. The operative and non-operative treatment of deep thrombophlebitis will be discussed and pertinent case material will be included.

Sponsor: Provident Hospital
Replays: Monday, February 17, 1969 12:30 P.M.
Wednesday, February 19, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

FEBRUARY 21, 1969—12:30 P.M.

HYPERTENSION

R. Patterson Russell, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

In considering treatment of the hypertensive patient the following will be reviewed: role of the initial evaluation; aims of and indications for treatment; currently effective pharmacotherapeutic agents and results of therapy.

Sponsor: Baltimore County General Hospital
Replays: Monday, February 24, 1969 12:30 P.M.
Wednesday, February 26, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

FEBRUARY 28, 1969—12:30 P.M.

TROPHOBLASTIC DISEASE

Griff T. Ross, MD
National Institutes of Health
Bethesda, Maryland

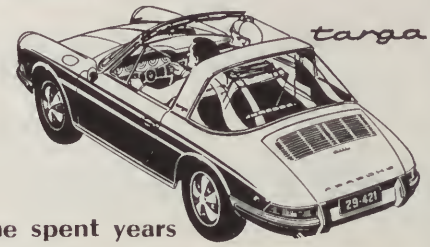
Results of chemotherapy of gestational trophoblastic neoplasms—metastatic and non-metastatic—will be presented. Factors influencing results will be analyzed and discussed. The diagnostic maneuvers necessary to early recognition will be emphasized.

Sponsor: Frederick Memorial Hospital
Replays: Monday, March 3, 1969 12:30 P.M.
Wednesday, March 5, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

MEDIC 1968-1969 STANDARD WEEKLY PROGRAM SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8						
9			LECTURE REPLAY			PEDIATRIC GRAND ROUNDS J.H.H.
AM 10						
11						MEDICAL GRAND ROUNDS J.H.H.
11:30						
NOON 12		MEDICAL GRAND ROUNDS U. OF M.				
12:30	LECTURE REPLAY				MEDIC LECTURE	
1						
1:30						
2			LECTURE REPLAY		NEUROLOGY GRAND ROUNDS U. OF M.	
3						
PM 4	PEDIATRIC GRAND ROUNDS - J. H. H.					
5						
6						
7						
8			LECTURE REPLAY			
9						

PORSCHE



Porsche spent years developing a great competition car so you could have fun driving to work.



Both body styles available in four engines:
912 - 911T
911E - 911S

Sportomatic available on 911 series only

40 West VOLKSWAGEN Phone: 744-2300 6624 Baltimore National Pike West of Beltway Exit 15 on Rt. 40 West

Help for the Alcoholic:
HIDDEN BROOK
Understanding care in an atmosphere conducive to Recovery



Request Brochure. Call 734-7554
Thomas Run Rd. Belair, Md. 21014

— *When the Need Arises* —

- **NURSES—**
—Registered or Practical
- Nursing Companion—Complete care of the semi-invalid or aged living alone
- Qualified women of highest character

CLIFFORD'S
FAMILY CARE SERVICE
8817 Littlewood Rd. NO 8-7710
Baltimore, Md. 21234



Legs don't come in exact sizes

No two legs are alike . . . not even on the same patient, and the usual "small, medium and large" sizes of elastic stockings will not be effective for the majority of your patients.

That's why *Jobst Venous Pressure Gradient®* supports are custom-made, and precisely fitted to the individual patient with a long series of careful measurements.

Even more *important* than the perfect fit, are the *exact* counterpressures built-in to your own prescription!

Jobst Venous Pressure Gradient® elastic stockings are a treatment of *choice* for leg ulcers, varicose veins, stasis dermatitis, postmastectomy lymphedema, post-phlebitis syndrome, post-fracture, post-operative and injury edema.

For full information, have your secretary mail the coupon below. Or if you have an immediate problem, just call the number on the coupon. You will find out why we named them "Service" Centers.

Jobst Service Center, Suite 415, Medical Arts Bldg., 101 W. Read St. Baltimore 21201, Phone (301) 539-0560



NAME _____

INSTITUTION _____

ADDRESS _____

CITY, STATE, ZIP _____

Moving UP . . .

As the busy professional man's practice moves up, his need for proper tax records increases.

More and more professional men recognize the value of Federated's accurate, out-of-office Bookkeeping and Tax services and appreciate the savings in office time and expense.

Call or Write:

K. Merrill Sumey, Resident Manager

FEDERATED BUSINESS SERVICES, INC.

P. O. Box 580

Randallstown, Maryland 21133

Telephone—655-2552

HOME OFFICE—BOSTON, MASS.



CANCER, A MANUAL FOR PRACTITIONERS, fourth edition, published by the American Cancer Society, Boston, Mass. 1968.

Each chapter of this publication has been completely revised and rewritten by recognized authorities in the diagnosis and treatment of cancer.

The purpose of this manual is to aid practitioners in the early diagnosis of cancer and to give them an understanding of its treatment and prognosis. Diagnosis is stressed but no attempt is made to go into the technical details of cancer therapy.

SYNOPSIS OF SURGERY, Richard D. Liechty, MD, and Robert T. Soper, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

This book was conceived in the light of the inevitable change in both medical school teaching and the textbooks of medicine. The authors state that basic clinical subjects must be taught as "core courses" to provide time for individual study and textbooks must adapt to this evolution in medical education.

The concept of teaching the essentials of surgery to the beginning student in the field, whether he is in medical school or many years out of school, is effectively put across in this volume.

SYMPOSIUM ON OCULAR THERAPY, Irving H. Leopold, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

This publication records the information presented at the Drug Symposium of the American Academy of Ophthalmology and Otolaryngology and the Association for Research in Ophthalmology meeting held in Chicago in the fall of 1967.

All the presentations are current and differ from those of earlier volumes. The material has been kept practical, fundamental, and timely; also, the Symposium is published every year; so the data is current and available to all those interested in it.

BRAY'S CLINICAL LABORATORY METHODS, John D. Bauer, MD, Philip G. Ackerman, PhD, and Gelson Toro, PhD; The C. V. Mosby Co., St. Louis, Mo. 1968.

This new edition has been extensively revised and updated, the source material being lectures given to residents in clinical pathology. Obsolete and out-of-date material has been eliminated.

Those with reference libraries would do well to purchase this book to be sure they have the most current literature available in this area.

HANDBOOK OF PEDIATRIC MEDICAL EMERGENCIES by Charles Varga, MD; The C. V. Mosby Co., St. Louis, Mo. 1968.

This is the fourth edition of this book which is now as current as medical literature can be on the subject. Ten of the chapters have been completely rewritten and most of the contributions in this edition are new.

The author points with some pride to the fact that the reorganization of the book is due in part to his experiences with his son's emergencies which "first taught me what it really means to be an anxious parent."

This is a worthwhile addition to any medical library.

SURGICAL PATHOLOGY by Laurence V. Ackerman, MD, and Harvey R. Butcher, Jr., MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

This fourth edition of Surgical Pathology has been extensively revised. The section on tumors of the skin has been completely rewritten; and the place of electron microscopy in surgical pathology has again been included and expounded upon.

The book can only be an introduction to the vast field of surgical pathology: the pathology of the living. It does not pretend to replace in any way the textbooks of general pathology, its purpose being merely to supplement them.

The contents are not as complete as they might be because emphasis has been placed on the common rather than the rare lesions and are, to a great extent, based on the author's personal experiences.

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



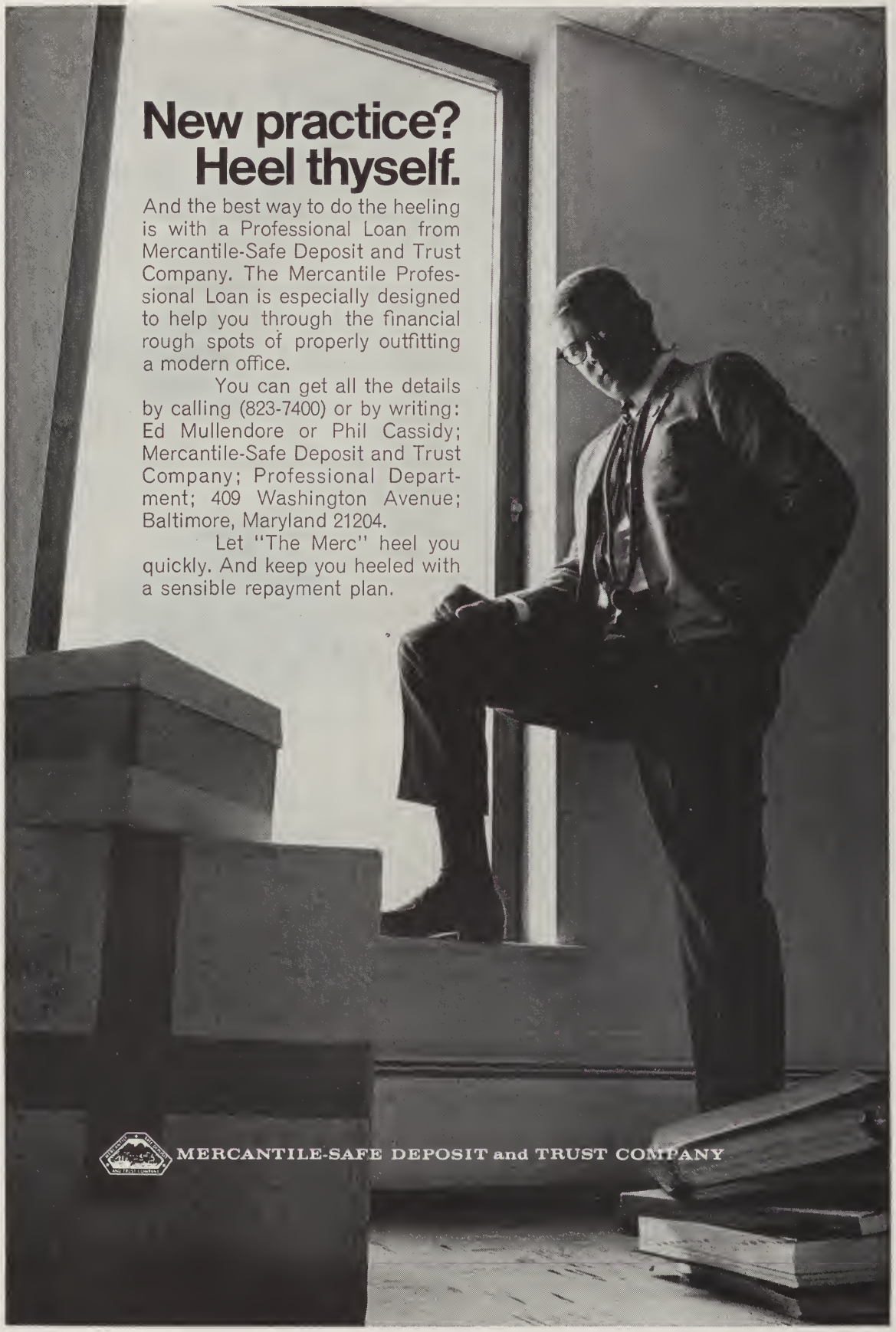
We Also Make
Artificial Arrangements

FLORISTS TELEGRAPH DELIVERY F.T.D.

Geo. **RADEBAUGH** *& Sons*

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300


New practice?
Heel thyself.
And the best way to do the heeling is with a Professional Loan from Mercantile-Safe Deposit and Trust Company. The Mercantile Professional Loan is especially designed to help you through the financial rough spots of properly outfitting a modern office.
You can get all the details by calling (823-7400) or by writing: Ed Mullendore or Phil Cassidy; Mercantile-Safe Deposit and Trust Company; Professional Department; 409 Washington Avenue; Baltimore, Maryland 21204.
Let "The Merc" heel you quickly. And keep you heeled with a sensible repayment plan.
MERCANTILE-SAFE DEPOSIT and TRUST COMPANY

THE MONTH IN WASHINGTON

The incoming Administration work on a health program was started with President-elect Richard Nixon's appointment of John Dunlop, a Harvard University professor, to head a special task force.

Dunlop, 54, is a prominent economist and an expert in the manpower field. He has been a frequent adviser to the federal government since 1948.

In a letter to employees of the Department of Health, Education and Welfare, Secretary Wilbur J. Cohen, who will return to teaching at the University of Michigan, listed 13 health goals for the 1970s. He previously had said that his teaching position would leave him time to work for new and expanded health programs.

Most of the goals are noncontroversial, and Cohen did not elaborate on details of implementation where controversy arises. The goals include:

• Continued expansion of medical research and more rapid dissemination of new knowledge to prevent and cure illness. • Elimination of economic barriers to medical care, through comprehensive health insurance and other public and private programs. • Major reduction in infant mortality and early childhood diseases. • Elimination of malnutrition. • Improvement in the organization and delivery of medical care, with continued emphasis on high quality. • Widespread transplantation of human organs and development of artificial organs. • Expanded prevention and improved chances of recovery from heart disease, stroke, and cancer. • Increase of health manpower and better use of professional skills. • Elimination of large mental institutions and expansion of community mental health centers accessible to all. • Family planning services available to everyone. • Improvement in the quality of the environment, with major reduction in air and water pollution. • Reduction of alcoholism, drug addiction, mental illness and mental retardation, and accidents. • Elimination of smallpox, diphtheria, polio, whooping cough, and measles.

*** *** ***

Developments in the drug field include starts on tests of an old drug in treatment of pneumonia and a new one for Parkinson's disease.

The National Institutes of Health started a wide-spread test of a polyvalent pneumoncoccal vaccine that was discarded 20 years ago with the entrance of antibiotics. Edwin M. Lerner, MD, coordinator of the test program, said it had been demonstrated that persons die of pneumonia because of early stage damage and that antibiotics have not been a cure-all. The old vaccine, manufactured by E. R. Squibb and Sons, was licensed and found effective in 1948, but was taken off the market in 1952 because of lack of sales.

"Penicillin was the cure-all in those days," Dr. Lerner said. "It was felt that there was no need to vaccinate people. After all, we thought we could cure them."

The Public Health Service announced a program to test an experimental drug in treatment of Parkinson's disease. Robert Q. Marston, MD, Director of the National Institutes of Health said the drug, L-DOPA, may help "up to 75% of patients." But he cautioned it has "serious and unpleasant side effects" which must be carefully checked.

Other developments in the drug field included:

• The Pharmaceutical Manufacturers Association disputed the finding of an HEW Task Force on Drugs that a $41.7 million saving could have been obtained by use of generic instead of brand name products in 67 of the 409 prescription drugs used most often by elderly persons. C. Joseph Stetler, PMA president, said the claim was not documented and was based "on the unproven assumption that prescriptions written by generic name cost substantially less."

• A Food and Drug Administration Advisory Committee said that existing data on whether birth control pills can cause cancer of the cervix is still inconclusive. The Advisory Committee on Obstetrics and Gynecology repeated the recommendation of the World Health Organization that all women using birth control pills undergo 6-to-12 month medical examinations.

• The government has drawn up a national drug system to permit computerized processing of drug data. The code is designed to provide the needed

common language in which to communicate rapidly and accurately essential information about drugs. The code was drawn up by HEW and the Drug Trade Conference, which represents drug manufacturers and distributors.

*** *** ***

Regional Medical programs, a majority involving continuing education of physicians, are now underway in 24 areas, with 261 separate projects being carried out, according to a government report.

Thirty-one regions have not yet embarked on specific programs.

States and regions with the most listed projects to date are Tennessee (mid-South), 27; Missouri, 25; Texas, 24; South Carolina, 16; Intermountain (Utah, Wyoming, Montana, Idaho, Nevada), 16; Michigan, 15; Georgia, 14; Kansas, 14; Washington-Alaska, 4; Albany (N. Y.), 10; Memphis (Tenn.), 10; California, 9; Rochester, (N. Y.), 9; and Oregon, 7.

*** *** ***

The nation's largest mental institution, Saint Elizabeth Hospital, Washington, D. C., will be converted to a model of modern mental health services, training, and research by the National Institute of Mental Health.

The National Center for Mental Health Services training and research will be headed by Sherman N. Kieffer, MD, Assistant Surgeon General of USPHS.

The new national center will have three divisions. One is the Saint Elizabeth Hospital-Division of Clinical and Community Services. In collaboration with the D. C. Department of Health, this division will operate the area D Community Mental Health Center which includes much of Southeast Washington. It will also provide active treatment, care and rehabilitation services for the beneficiaries of Saint Elizabeth.

A division of intramural training, will administer an expanded institute program to train new types of auxiliary mental health manpower and to test new training techniques.

The third division will be responsible for the development of new approaches in clinical research.

*** *** ***

A deadly brain and skull defect was found in four of 14 aborted fetuses whose mothers used LSD, a George Washington University Geneticist reported.

Dr. Cecil B. Jacobson, re-

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected for possible growth of principal and income.

NO SALES CHARGE
NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

save time! save trouble! save money!

Forms & Stationery For Medical Offices

Our Professional Service Division makes a specialty of stocking many forms for the profession.
It's so easy and economical to have all your stationery requirements taken care of by folks who understand your need for quality, accuracy and service.
We'll be happy to be your "Stationery Room," delivering your printing as you use it, promptly.
Let's get together – today!

EAGLE PRINTING COMPANY, INC.
1021 Cathedral Street
2 Minutes Away—at 752-5400

porting to a District of Columbia Medical Society meeting, said he also found "moderate" to "severe" flaws in chromosomes of "at least 50%" of 75 female LSD users. The flaws are in genetic material and could impair offspring, he said.

Jacobson and his associates said they found their subjects by advertising in an underground newspaper for pregnant LSD users, "No Questions Asked." Among the group he has studied, he said, there were 22 normal births and 35 abortions, only 14 of which produced fetuses intact enough for study.

Four of the 14 had a disease called "exencephaly" which normally shows in less than one-half of 1% of babies, he said. It is fatal, he said. One characteristic is that the brain is completely outside the skull.

Eighty per cent of the women studied were unmarried, Jacobson's aides said. Some had taken as little as one dose of LSD and others had taken it numerous times.

*** *** ***

Man is threatened with self-destruction because he has damaged, ignored and contaminated "the earth that gives him life," according to a federal government official.

Charles C. Johnson, Jr., Administrator of the newly created Consumer Protection and Environmental Health Service in the Department of Health, Education and Welfare, said the threat from pollution, unsafe food, drugs, water and chemical additives to food—among other things—is increasing each year.

Johnson spoke at a symposium on Human Ecology. Ecology is the branch of science dealing with the relationship between people and their environment.

"With regard to the physical environment, we have reached, or at the very least are rapidly approaching, a critical point," Johnson told the gathering of scientists, lawyers, sociologists, engineers and other specialists.

"Every year, pollution gets worse, rather than better; the threat from unsafe food, drugs, water and a variety of consumer products is increasing; the quality of American life, particularly urban life, is deteriorating in a morass of environmental problems so complex as to appear almost beyond remedy," Johnson said.

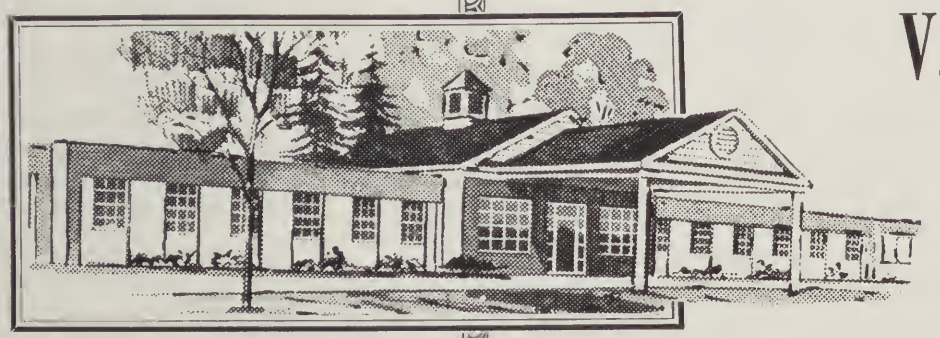
★ This extended care Nursing Home is Approved by the Joint Commission on Accreditation of Hospitals

★ One story new fire-safe construction.

★ No steps, ramps or elevators needed.

★ Inspection invited. Reasonable rates.

★ All facilities available to private physicians.



★ Professional Total Care Program

★ Continuous Physical Rehabilitation by registered therapists in specially equipped department.

PHONE VALLEY 8-6500

Where your convalescent
Elderly, Bedfast or Disabled

Enjoy being special

V. I. P.'s

(VERY IMPORTANT PARENTS)

Dulaney Towson

NURSING & CONVALESCENT HOME

111 West Road, Towson

Off York Rd. Beltway Exit 26 South



MRS. HARRY L. BERMAN, EDITOR

woman's auxiliary

Workshops

Six State Auxiliary Chairmen returned from attending Regional Workshops in Boston on October 17-18 full of enthusiasm and information to impart to their County Chairmen in "mini-sessions" at Med-Chi, following a Board Meeting on October 30th. They were Mrs. Elmer G. Linhardt, Education Research Fund; Mrs. Wallace A. Sadowsky, Membership; Mrs. George S. Malouf, Safety and Disaster Preparedness; Mrs. G. Allen Moulton, Community Health Services; Mrs. Robert J. Dawson, Health Careers; and Mrs. H. Leonard Warres who substituted for Mrs. William C. Brewer, Mental Health. All were deeply impressed by the lectures, group discussions and intense periods of instruction.

Mrs. Elmer G. Linhardt learned of an amazing number of fund-raising projects and gleaned a vast amount of material in the two-day session. She was furnished with detailed information relative to ERF Contributions to medical schools, Bio-medical Research Institute and Student Loans. She reported on other state-level projects and ventures related to fund-raising which had proved highly successful.

Mrs. Warres brought back numerous suggestions for programs and activities in Mental Health which included education, service, program-planning and fund-raising. Discussions were many-faceted on unmet needs and services available in emotional and mental illnesses. Movies are available to illustrate the pitfalls of narcotic addiction, suicide prevention and the mistreatment of young children. The movies and talks, professionally produced and financed by auxiliary groups, can be distributed to high schools, youth groups and religious centers as are those dealing with Health Careers on which Mrs. Dawson reported to her County Health Careers Chairmen. In that area the talks and movies were designed to call attention to the many fascinating medical and paramedical professions and foster interest in them.

Mrs. Moulton was advised on assessing the most needed health services in the community. "Friendly visitors," meals for shut-ins, homemakers and health aides were examples of areas where support was offered by the medical auxiliaries.

Mrs. Malouf dispensed material and advice on how to handle situations in many kinds of emergencies, including a training course for babysitters, Block Mothers to aid troubled children enroute to and from school, poison prevention and preparedness for disaster.

Mrs. Sadowsky, working in the field of membership and programming, stressed the importance of planning interesting meetings with emphasis on stimulating programs to enlarge membership attendance and meet the health-related needs of each community.

County Workshops

Harford County Auxiliary continues to support the Center for the Retarded and plans are underway for a residential unit.

Washington County Auxiliary has had gratifying results in presenting National's Package Program "Mental Health of Children." PTAs from twenty-three elementary schools have requested it to date.

MEDICAL NEWS

Liam Haim, MD, of Silver Spring has been elected a Fellow-Elect of the American College of Obstetricians and Gynecologists.

* * *

The *Dictionary of International Biography,* Fifth Edition, 1968-1969, has included **Kenneth W. Taber, MD,** of Churchville, in its biographical listing.

D.I.B. is a record of contemporary achievement and is distributed in 112 countries. The Fifth Edition contains more than 14,000 biographical sketches.

Dr. Taber was cited for his distinguished career as physician and surgeon. His main field of interest is radiology.

* * *

The American Academy of Pediatrics has urged that health insurance plans provide more comprehensive coverage for the delivery of medical services to infants and children. Spokesmen for the Academy recently stated that a major portion of child health care is not covered by health insurance.

The AAP statement defined comprehensive pediatric care as "all services given to infants, children and adolescents necessary to establish and maintain optimal health.

"When indicated, these services should be rendered on a 24-hour basis by a personal physician or his aid acting under the physician's supervision either in the office, hospital outpatient department, or other facility."

* * *

The Baltimore Academy of Surgery was recently established to promote high standards in the profession and provide a forum for scientific discussion.

George D. Zuidema, MD, director of the department of surgery at The Johns Hopkins School of Medicine, has been elected president of the 51-member organization.

The Academy held its first scientific discussion in November and plans to hold at least two more meetings before June.

The formation of the group is the culmination of over a year's effort by **George G. Finney, Sr., MD,** former chief of surgery at Union Memorial Hospital, and **George H. Yeager, MD,** medical director of the University of Maryland Hospital.

Other officers of the Academy include: **Arnold M. Seligman, MD, vice president; John N. Classen, MD, secretary; T. Brannon Hubbard, Jr., MD, treasurer; Karl F. Mech, MD, recorder; and Richard W. Steenburg, MD, program chairman.**

* * *

Sheila C. Mitchell, MD, has been named Assistant to the Director, National Heart Institute.

In her new post, Dr. Mitchell will participate in, administer, and coordinate NHI collaborative studies and targeted research activities in congenital and rheumatic heart disease. She will also serve as executive secretary for the NHI Executive Committee and for special review panels and as project officer for a training contract with the Board of Pediatric Cardiology to evaluate testing and training procedures in the congenital heart disease field.

* * *

Since the inception of the AMA Volunteer Physicians for Viet Nam, July 1, 1965, ten Maryland physicians have volunteered to spend at least 60 days in provincial hospitals, supplementing drastically inadequate resident medical staffs.

From Baltimore, the volunteers include **Michael B. Flynn, MD, Stephen M. Nagy, Jr., MD, Thomas H. Powell, MD, Glendon E. Rayson, MD, and Donald K. Wallace, MD.**

Robert E. Eby, MD, Olney; **Louis Padovano, MD,** Woodstock; and **Patrick A. Reardon, MD,** Seabrook, are the others from the state.

Both Dr. Padovano and Dr. Powell volunteered for a second tour of duty.

* * *

Karim F. Rashad, MD, of Baltimore, was recented named a Diplomate of the American Board of Anesthesiology.

* * *

The following physicians will serve on the **Committee on Medical Practice of The Professional Forum** through 1970: **William E. Gilmore, MD, Chairman; Fred N. Cole, MD, vice chairman, Thoracic Surgery; Newland E. Day, MD, vice chairman, Internal Medicine; Joseph H. Hooper,**

Jr., MD, vice chairman, Surgery; Raymond L. Markley, Jr., MD, vice chairman, Gynecology; Robert McFadden, MD, assistant vice chairman, Surgery; Alfred G. Ossman, Jr., MD, assistant vice chairman, Medicine; John M. Rehberger, MD, vice chairman, Otolaryngology; Douglas H. Stone, MD, assistant vice chairman, Surgery (on leave of absence); Henry L. Wollenweber, MD, vice chairman, Pathology.

Selected to serve on the **Committee on Dental Practice** are **Paul S. Keller, DDS, chairman,** and **Conrad L. Inman, Jr., DDS, vice chairman.**

Officers of The Professional Forum are **J. E. Rytten, president; Newland E. Day, MD, vice president,** and **Howard E. DeMuth, Jr., secretary-treasurer.** Mr. Rytten is a criminologist and Mr. DeMuth is an attorney.

Mr. John Sargeant will continue to serve the Committee on Medical Practice as liaison officer between the Forum and county, state and national medical associations.

* * *

Harry M. Robinson, Jr., MD, professor and head of the division of dermatology at the University of Maryland School of Medicine, has been awarded a three-year, $300,000 grant from the Vocational Rehabilitation Administration to establish a special regional facility for rehabilitation applied to dermatology—the first of its kind anywhere in the world.

Very few of the general rehabilitation centers ever accept patients unable to work because of chronic skin trouble, Dr. Robinson stated. According to a recent survey, 76% of such centers in the United States and Canada report they do not admit patients whose primary cause of disability is dermatosis. This creates an unfortunate situation for a worker suffering from a skin eruption caused or aggravated by substances he handles on his job, because he may be incapacitated for a much longer period of time than a person who breaks a leg as the result of an industrial injury.

Many chronic skin patients do draw Workman's Compensation benefits and in Maryland, during fiscal year 1963, 68% of the nonfatal claims that the Medical Board for Occupational Disease reviewed and allowed without contest involved workmen with occupational dermatosis.

Dr. Robinson's primary objective is to study rehabilitation problems presented by patients with various skin problems, and to establish a multidisciplinary program for the management of those problems.

"Early diagnosis and prompt referral for rehabilitation are the key to success," Dr. Robinson said. "Obviously, not all patients are suitable candidates for rehabilitation, but prolonged delay may mean loss of motivation. Medical care, vocational guidance, and rehabilitation can all be carried out at the same time. Our ultimate goal is to restore the injured or handicapped to useful and productive life."

Dr. Robinson is recruiting staff now for the new facility, which will be located on the second floor of Howard Hall, near the present Rehabilitation Unit.

* * *

Robert M. Heyssel, MD, has been named director of the outpatient services at The Johns Hopkins Hospital, a position vacant since **John C. Harvey, MD,** left the post last January 1 to become medical director of the new Good Samaritan Hospital.

Dr. Heyssel, who is also associate professor of medicine and associate dean for health care programs for The Johns Hopkins University School of Medicine, will be administratively responsible for the development and operation of the hospital's outpatient care programs. As director of a hospital department, he will serve as a member of the medical board.

Before joining The Hopkins staff in May, Dr. Heyssel served for nine years, most recently as associate professor of medicine, on the faculty of Vanderbilt University School of Medicine.

At Vanderbilt he also was director of the department of medicine's division of nuclear medicine and biophysics, and director of the Vanderbilt University Hospital radioisotope center.

As a result of his research, Dr. Heyssel was first to describe the dose-response relationship of radiation to human leukemia in a nonselected large population. He also did the first large scale study of absorption of Vitamin B12 from natural foods, and made the first reasonably based estimates of minimal daily dietary requirements for Vitamin B12.

He also has done research on iron metabolism, blood platelets and health care systems.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



Help clear up that miserable stuffed-up feeling with Dimetapp. Each hard-working Extentab brings welcome relief from the stuffiness, drip and congestion of upper respiratory conditions for up to 10-12 hours. Yet, patients seldom experience drowsiness or overstimulation. The key to success is the Dimetapp formula: Dimetane (brompheniramine maleate)—along with phenylephrine and phenylpropanolamine, two time-tested decongestants. They get the job done... in a hurry.

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripher vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thromb cytopenia, have been reported on rare occasions. Drowsiness, lassitud nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

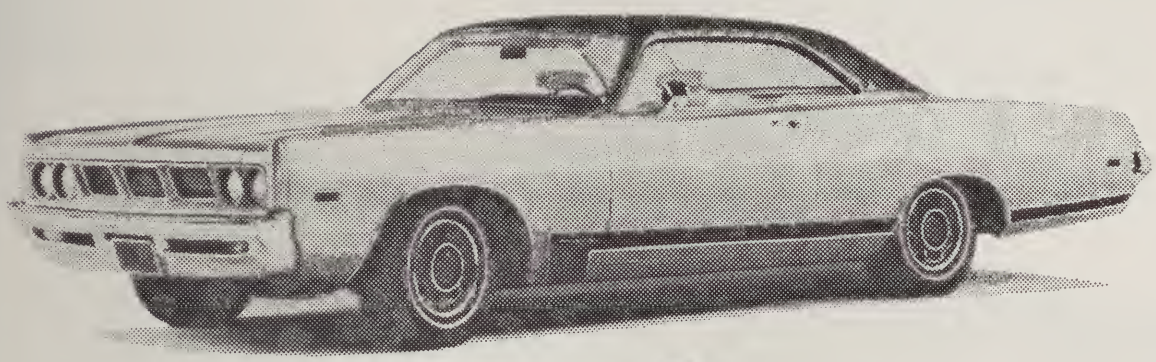
A.H. ROBINS COMPANY
RICHMOND, VA. 2322
A·H·ROBINS

in sinusitis, colds, U.R.I.
Dimetapp® Extentabs®

(Dimetane® [brompheniramine maleate], 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.)

up to 10-12 hours clear breathing on one tablet





our Final Net Figure figures to be lower on a '69 DODGE

CENTRAL DODGE

Baltimore's
Downtown Dodge Dealer
1111 Cathedral Street
Phone 685-3797



P.D.Q. SERVICE ESPECIALLY FOR DOCTORS *Professional, Dependable, Quick Auto Repairs. Our service department has instructions to give precedence to doctors in immediate, accurate electronic diagnosis and prompt, expert therapy on any make car to avoid unnecessary delay in your valuable service to the community.*

So he'll breathe easier:

relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

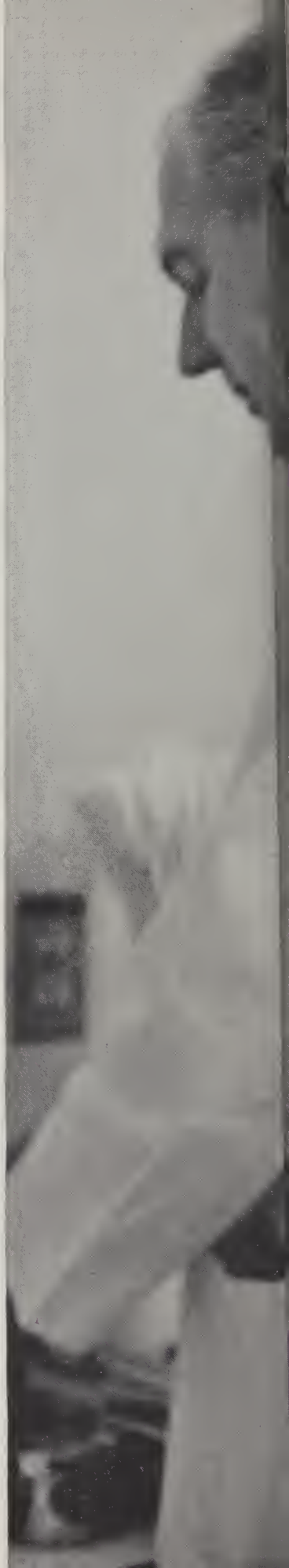
Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

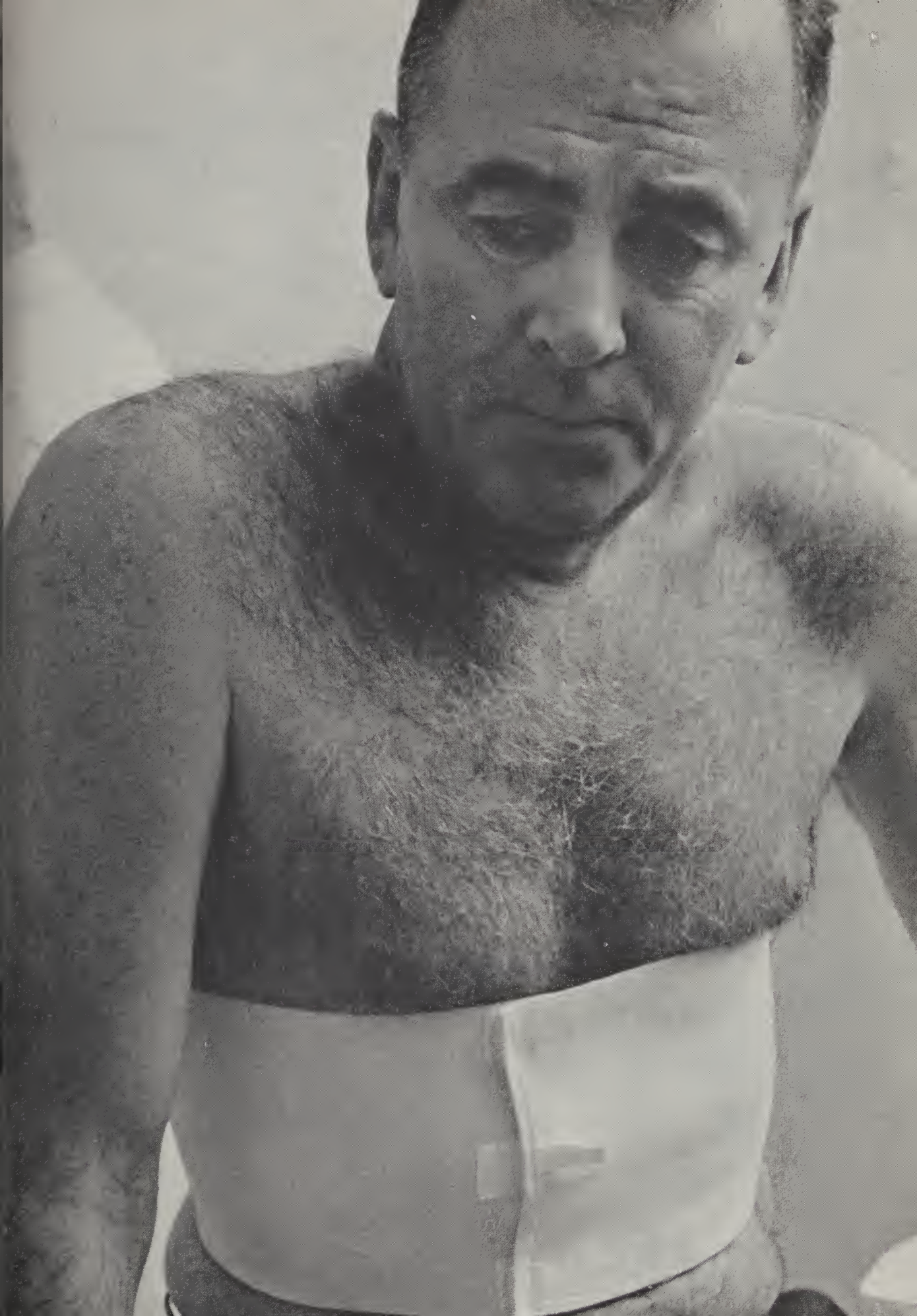
Overdosage: See precautions section for management of overdosage.

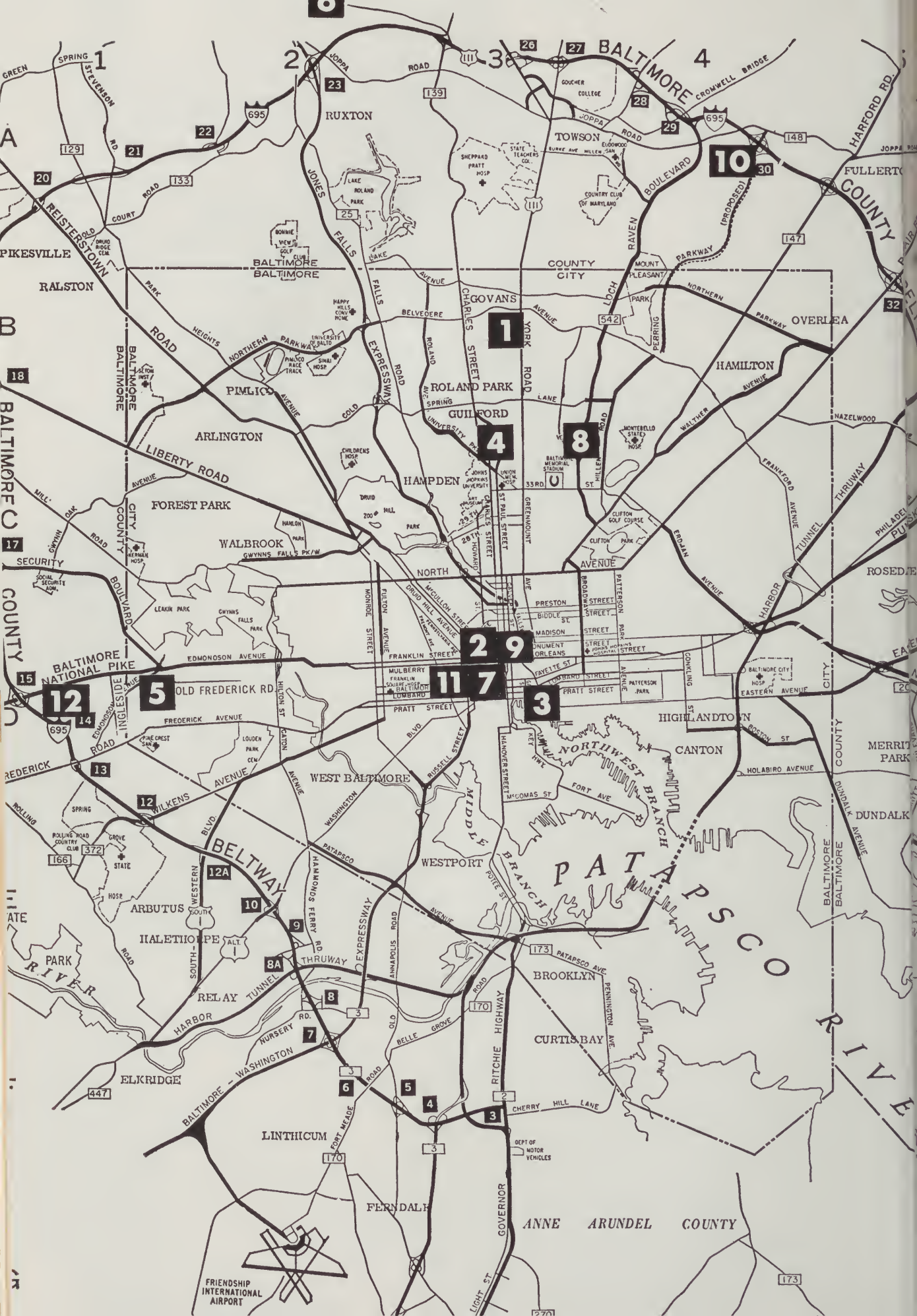
Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.






BALTIMORE
TOWSON
RUXTON
PIKESVILLE
RALSTON
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
ARLINGTON
FOREST PARK
WALBROOK
PIMLICO
OVERLEA
HAMILTON
NORTH
MADISON
PRESTON
BIDDLE
FRANKLIN
MULBERRY
LOMBARD
PRATT
FAYETTE
EDMONDSON AVENUE
FREDERICK AVENUE
OLD FREDERICK RD
BALTIMORE NATIONAL PIKE
LIBERTY ROAD
HIGHLANDTOWN
CANTON
WEST BALTIMORE
WESTPORT
BELTWAY
ARBUTUS
HALETHORPE
RELAY
ELKRIDGE
LINTHICUM
FERNDALE
BROOKLYN
CURTIS BAY
DUNDALK
PATAPSCO
NORTHWEST BRANCH
MIDDLE BRANCH
PATAPSCO RIVER
ANNE ARUNDEL COUNTY
FRIENDSHIP INTERNATIONAL AIRPORT
BALTIMORE - WASHINGTON
CHERRY HILL LANE
HOLABIRD AVENUE
EASTERN AVENUE
BOSTON ST
FORT AVE
McCOMAS ST
PATAPSCO AVE
PENNINGTON AVE
DUNDALK AVENUE
HARBOR TUNNEL THRUWAY
BALTIMORE CROMWELL BRIDGE
HARFORD RD.
JOPPA ROAD
YORK ROAD
CHARLES STREET
FALLS ROAD
JONES FALLS EXPRESSWAY
RITCHIE HIGHWAY
GOVERNOR
PORT MEADE
DEPT OF MOTOR VEHICLES
BALTIMORE CITY HOSP
SECURITY
GWYNN OAK
COUNTY
CITY

Restaurants of Distinction

Locations indicated by numbers on map

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE

ltimore 1, Md. MU 5-6790

CARRY-OUT SERVICE

SPECIAL LUNCHEON and DINNERS

RIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.

Sunday 12 Noon to 3 A.M.

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD

Cocktails Mexican Beers

Tuesday thru Sunday

Open 5:00 P.M.---12:00 P.M.

Dinner and Snacks

Closed Monday

Phone 435-9858

7

Miller Bros.

"The Place to Eat"



NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call 752-4822

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*

Your Host

Tom d'Anna

539-9021



10



SPECIAL AT THE

FABULOUS CLUB VENUS

An Evening for Two . . Only **$15**

Offer good every night except Saturday

Make Reservations Now

Perring Plaza Shopping Center—Beltway Exit 30

For Reservations Call NO 8-2232

9

Cork 'n Bottle Restaurant

STEAK — SEAFOOD — PRIME RIB

COCKTAILS

LUNCHEON — DINNER

Major Credit Cards Honored | Private Party Rooms

22 E. FAYETTE ST. BALTIMORE, MD.

½ *Block from Charles Center*

539-1268

Dobbs House

Breakfast-Luncheon-Dinner

Banquets-Meeting-Private Parties

We Cater Wedding Receptions

Located in Quality Court Motel—West

U.S. Route 40 & Beltway Exit 15

5801 Baltimore National Pike

744-1510

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

5



Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS

Finest Sea Foods

Prime Meats

5653 Old Frederick Road

East of Ingleside Ave., off Baltimore National Pike

TED KUCHTA, *Manager* Phone 744-0223

MILTON INN

Circa 1740

Dine Amid Early American Charm

Warm, Gracious and Inviting

Selected By Life & Time Magazines as One of America's Finest Inns

Lounge & Dining Room Available for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.

PARKS 771-4366

4

Broadview Restaurant

Cocktails • Dinners • Luncheons

Private Entertaining Facilities

116 W. University Parkway at 39th St.

CALL CH 3-1216

3

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

Baltimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center

Open 12 noon to 3 A.M.—Closed Mondays

For Reservations Call 685-2811

2 blocks south of the Flag House

300 ALBEMARLE STREET

John Ruxton
Trust Department
Equitable Trust Bank
Baltimore, Maryland 21203

Please send me more information on HR-10

Name_____

Address_____

City_____State_____Zip_____

This coupon can cut your taxes, provide for your retirement, and put more money in your pocket.

The Keogh Act, HR-10, is finally law. And it enables you to set up a retirement plan, cut your taxes, and have more money in your pocket. But it won't do a thing for you unless you act on it. So do it now. Risk a 6¢ stamp. We'll send you a booklet telling you simply, clearly, what the advantages are to you.

Equitable Trust Bank

Baltimore, Maryland 21203
Member Federal Deposit Insurance Corporation

Distinguished Dining
Whenever the holidays,
Whatever the reasons,
It's the



The Inn for all seasons.

And for an "Adventure in Shopping," be sure to visit the Inn's BARN SHOP. Antiques, Reproductions, Imports, Contemporary Gifts.

30 minutes from downtown Washington
Rte. #97 – Georgia Ave., Olney, Md.
From Baltimore, Rte. #29—#108—#97
For Reservations — Phone: 929-1717

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545

When Should A Physician Assist the Surgeon?

When is it obligatory that an operating surgeon have a physician assistant present and scrubbed at the operating table?

The Joint Commission on Accreditation of Hospitals stipulates that there must be a physician assistant present "in any procedure with unusual hazard to life." The American College of Surgeons, as a member of the JCAH, supports this as a minimum requirement. The determination of what constitutes "unusual hazard" rests therefore with the conscience of the operating surgeon and is part of his responsibility to his patient, but the surgeon must be prepared to defend his decision before the medical staff and the governing body of his hospital.

Ideally, perhaps there should always be a competent surgeon backing up the operator during every surgical procedure in the event of an unanticipated accident to the latter. Such sudden incapacities must be rare indeed and their potentiality can not be compared with the necessity for a co-pilot of a plane. There are frequent circumstances when it is clearly not feasible to have a second surgeon, or even a physician assistant, on the operating team. Moreover, there are simple procedures at which it would be superfluous to insist upon a physician assistant.

The problem is where to draw the line, and the delineation must be made by the conscience of the surgeon. It is fatuous to propose, as certain medico-legal experts and even state licensing bodies have recently done, that there should be a physician assistant at every "major surgical operation." This begs the question. No group of surgeons has ever been able to agree upon a definition of "major" versus "minor" surgical procedures. The truth is that the degree of hazard of an operation lies not so much in the nature of the procedure itself as in the age, obesity, condition, etc. of the patient. These are the factors which the operating surgeon must evaluate in each case and which will determine what constitutes adequate assistance.

Adolescence:

A Prominent "Disease" of the '60s

A subject that cuts across almost all fields of medicine is adolescence. The problems —emotional and medical—which confront the adolescent of the 1960's are not unique. In fact, they are as old as civilization itself. The big difference today seems to lie in the fact that these problems are more talked about, more publicized by all media, and possibly more criticized than ever before.

And then again, teen-agers have achieved a more prominent position in our social structure—by virtue of their number—and instead of concealing any behavior patterns which seem to deviate from the accepted norm, they blatantly announce them to the world. Today, with the hippie and yippie elements invading and destroying the once-solid family institution, wholesale sex is bragged about. Pregnant teen-agers don't try to hide their condition. Some even appear proud that they are about to become unwed mothers.

Despite the misplaced emphasis on deviate behavior during this decade, this is a major problem which the Adolescent Medical Center of Sinai Hospital is attempting to cope with. The AMC is divided into several sections—one deals with psychiatric problems, another with obstetrics, and another aspect is the Family Life Service. Although the center is still in its infancy, the results seem promising.

It is not necessarily a sex-oriented center but one cannot deny that most adolescent problems are created by a sex vs. morality conflict.

The purpose of the center is to provide a place where adolescents—boys and girls—can go for counseling, group discussion and therapy, if necessary. The teen-agers gather in their respective peer groups, thus insuring their uninhibited participation.

According to Herbert L. Yousem, MD, Director of the Family OB Clinic at the Center, aside from the definite group of retarded children referred to the center, "the remainder of the group has a normal intelligence and they are just actor-outers so to speak."

The following papers were presented during a meeting of the Baltimore City Medical Society on February 2, 1968, Zamoiski Auditorium, Sinai Hospital of Baltimore, Inc.

EMOTIONAL PROBLEMS OF ADOLESCENCE

KURT GLASER, MD
Departments of Psychiatry and Pediatrics
University of Maryland School of Medicine;
Clinical Director
Rosewood State Hospital;
Psychiatric Consultant, Adolescent Center
Sinai Hospital of Baltimore, Inc.

"Youth is disintegrating. The youngsters of the land have a disrespect for their elders, and a contempt for authority in every form. Vandalism is rife and crime of all kinds is rampant among our young people. The Nation is in peril."

—Unknown Egyptian priest
4,000 years ago

"Our youth now loves luxury. They have bad manners and contempt for authority. They show disrespect for their elders and love idle chatter in place of exercise. Children are now tyrants—not the servants of the household. They no longer rise when elders enter the room. They contradict their parents, chatter before company, gobble up their food, and tyrannize their teachers."

—Socrates
About 400 B.C.E.
—2,300 years ago

The reader is familiar with the anatomical, physiological, hormonal changes in adolescence and the concomitant psychological changes and conflicts.

This paper will deal with some of the psychosocial aspects of adolescence: the struggle between the drive for independence and the prolonged economic dependence; sexual drives and moral restriction; professed moral codes and practiced adult behavior; emergence from youth into adulthood and the search for identity; choice of career, conflict over immediate gratification of some desires versus postponement of hedonistic satisfaction for supposed greater satisfaction following prolonged education with its concomitant restriction of freedom, independence and reduction of self-esteem as a "not yet adult."

These conflicts lead to confusion and resentment toward the adult world which is blamed on one hand for causing much of the confusion and on the other hand for not providing the assistance and guidance for solving these conflicts. This resentment may lead to rebellion—and rebellion at times may manifest itself in the form of delinquent behavior. Delinquency, however, is not a problem of our generation; it has always been present to greater or lesser degrees and in a variety of forms.

Some of the peculiarities of *this* generation's adolescent problems, how they may differ from the last generation's and may be specific for our times are important items for us to consider. I do not want to imply that they are greater in value, in degree, in severity, or in depth *now* than they were in earlier years. I only want to draw attention to the differences and to factors which may be specific for the events in the 1960's.

Dependency vs. Independency

Longer *dependency* as a result of longer education needed in preparation for life in our technological society is a fact. At the same time we find more sophistication and knowledge in all fields of human endeavor at an earlier age since scientific, political, military, sociological and even personal events such as marriage, divorce, litigations and crimes of known personalities are spread with amazing rapidity through the news media and need little effort on the part of the individual to acquire. No longer is it necessary to read through newspapers and journals to acquire information and news from all over the world; it can be obtained, without reading ability, through radio or T.V., and even the most disinterested child is exposed to this information. This worldly knowledge, plus the ready availability of transportation, not only by car but also over long distances by plane, produce a sense of quasi-independence and a temptation toward using this available opportunity. Yet economically the dependency period has been prolonged, and those who hold the purse strings exert control, even if professing to allow freedom. The son who hears "you make your own decisions" knows that if father wants to stop him, all he has to do is pull the purse strings closed.

The physician's contribution can be anticipatory counseling for young parents to avoid prolonged suppressive child rearing practices in earlier childhood, and instead train the child to assume gradually a more self-reliant attitude and thus avoid his need for rebellion.

Sexual Problems

The sexual conflicts of the adolescent are well known. He is driven by organ and hormone development as well as curiosity to prove and test his virility, but he is restricted by moral rules.

Confusion and further conflict are added to ever-existing sexual conflicts of the adolescent by changing mores and the changing role of the woman. These changes are already accepted as *modus vivendi* by a large part of adolescent society, both male and female, but not by all, and certainly not by the majority of the parental generation. The great emphasis on and use of sex by the advertising and entertainment industry provides constant visual and auditory sexual stimulation. Often slanted, exaggerated and sensationalized news reporting of items, which only a generation ago would have been whispered only as gossip, constantly remind the child even long before he enters his teens of the blatant discrepancy between professed rules to live by and actual adult behavior. I am very glad to hear that educators are beginning to offer a family-life education program which will include a broader-based sex education. Our past efforts have been rendered ineffective by starting too late, saying too little, avoiding the real issues, and not allowing the child to react to what is presented.

The physician has a role here, not only by offering sex education to the individual patient when he is requested to do so and as he sees the need, but also by counseling the parents and impressing on them the need for a broad, early, and honest clarification. Since many parents are reluctant or unable to discuss this subject, parental education either directly or through literature or a combination of both is often a first step. Active support of the school program and participation in such a program is a further contribution the physician can make.

Parental Unavailability Plus Shrinking Family

The family structure has changed over the last decades with grandparents, aunts and uncles removed from the nuclear family and being of only limited availability to the children. Even the role of the maid has changed from the live-in maid, at times serving over two generations and almost a part of the family, to the once-a-week, ever-changing cleaning woman. I wonder just how significant the presence or absence of such a family servant in the house has been or is in many families. I have never seen a study about this subject but am convinced that its psychological significance is great and that many maids have made a greater impact upon the child than his socially active, absent mother.

Paternal absence or unavailability is again well known, and many a doctor is guilty of contributing to this social phenomenon. Often more traumatic than the physical absence is the emotional distance of the father who, even when present, buries himself in the newspaper or stares at T.V. Little is gained if both child and father watch T.V. or sit at sports events, hardly noticing each other's presence. Emotional and intellectual inter-

action is necessary to fulfill the paternal role.

Early counseling may influence some parents to arrange some part of their time so as to benefit the child for whom they profess to be willing to give everything. Often this "everything" is meant to be material goods only and does not include one's own time and affection.

Affluence

The almost unlimited availability of recreational facilities and material goods in many circles, not only among the wealthiest, and the emphasis on pleasure and luxury are evidently not enough to fill a young person's life.

To develop self-esteem, to feel like a person in his own right, to be somebody with pride in himself, to prove himself, a person must have a challenge, a task to achieve, a goal to reach. The young person, whose identity is not yet established and whose personality is not formed, is even more in need of this opportunity than the adult who can look back at past achievements or challenges he has met and whose need for new ones is less acute.

If we meet all needs, protect him from all dangers, prevent his mistakes or correct them for him we deprive the child of the opportunity to establish the identity which all persons need.

The youngster who makes a mistake and then corrects it, is wiser and prouder than the one whose mistake has been prevented by his mother and who has been made to feel infantile and incapable through this benevolent and yet really damaging protective act.

Mobility

Mobility from one geographic location to another has increased and the reasons are manyfold. Some such moves are unavoidable, some are desirable from one angle and undesirable from another, and some seem unjustified. What we physicians can do at times is to point out some effects which the move may have upon the various family members, and of which the parents may not be aware.

A known environment gives a feeling of security, even identity. Moving to the periphery of the city may mean isolation, transportation difficulties and increased dependency, separation from friends, different living standards and, of course, unfamiliar surroundings with regard to physical structures and persons.

Antisocial acts are more difficult to perpetrate towards friends, or friends of the family, while the "new kid," not yet accepted by the established clan, may find it easy to act out against people or property which he considers strange or even hostile.

I do not want to give the impression that delinquent behavior has its origin in a single cause, or even that uprooting, mobility and nonacceptance are major causes, but they are significant. Yielding to status pressure, advertising temptations and real or imagined social factors should be weighed in the light of the social and psychological impact a move has upon each family member. The physician may be the person who is familiar enough with the social structure of the community to give some guidance.

Scholastic Problems

Motivation toward longer education is often counteracted by immature wishes for early tangible results. Can the immature adolescent postpone the gratification of his dreams—constantly reinforced by advertisements and the affluent image of friends and neighbors? His parents often have achieved success, especially in the business world, without the formal education now deemed necessary for success. They, therefore, do not serve as an example. They also offer a standard of living which the child could only achieve after considerable education and delay. Early marriage and offspring again may create the conflict between "needs now" and "opportunities later." Is he willing to prolong his dependency upon his parents in order to achieve similar standards on his own strength, or does he want his own car *now* while partaking of his parents' comfort, only to find out years later that he is neither prepared to achieve these standards nor to give them up?

Push for College in Various Social Strata

Children in *lower socio-economic* groups have few examples of higher education in their midst. Anti-educational influence by peers who strive and succeed in immediately gratifying their needs with such visible results as a car, clothes and available cash for entertainment is strong. Most youngsters do not appreciate that these pleasures represent only a false sense of independence since the child's income can satisfy these hedonistic desires only while having food, shelter and medical needs provided by parents. Parents who on

one hand allow and support this freedom and on the other hand use their financial and factual control to limit the independence create a conflictual situation between themselves and the child.

The push for a college education in the *higher socio-economic* group for children lacking the intellectual qualifications for college work creates frustration and disappointment to parents and embarrassment over competitive failures with peers and siblings. From an early age the child is told, "You are no good unless you go to college," and is pushed toward certain categories of jobs requiring intellectual faculties which he may not have.

The old-fashioned way of starting at the bottom of the ladder and working one's way up, depending on ability and willingness to expend effort, is no longer accepted. Inappropriate study and career choice often leads to failure because of limited ability or motivation to take on the greater responsibility and expenditure of energy which the higher job requires. Backtracking and assuming a lower level, educationally or occupationally, is more difficult and traumatic to one's self-esteem than stopping at a comfortable level of ascent. The family physician can be of great service to the child by showing his interest in scholastic achievement and, in case of possible conflict, by urging the child to seek educational and vocational guidance.

The adolescent in rebellion may find the educational aims of his parents the most vulnerable areas to rebel against. His conscious desire to comply and to get the education the parents have outlined for him and the job which would meet his and his parents' desire is counteracted by resentment that this would not be *his* spontaneous decision but only compliance and submission to parental wishes and a further certificate of his powerless, dependent position.

Problems of Identity

The adolescent has left childhood and not yet entered adult society. He looks for his niche there and tries to find his position and the image he likes to see himself in when grown up. He is constantly questioning the established rules, laws, and customs and observing adult behavior. What he sees is not always very encouraging; in fact his criticism may be shared by a significant part of the adult society, and thus revolutionary movements or subcultures such as the hippies are born.

Summary

Most adolescents find the solution to the above conflicts through discussions with peers, parents, teachers, counselors, adults available through sports, social or political associations and through books. For them the problems are transient; they are the growing pains of the maturing process. For others, the problems and their solutions take on a more serious aspect.

Those who cannot find the solution or clarification they seek and cannot tolerate to live in a conflictual and often contradictory world may suffer from lack of self-respect and self-confidence, get depressed and even suicidal. The incidence of suicide and suicidal attempt is increasing, especially in the college population. The physician, whether as family physician or school or college physician or perhaps as neighbor and friend, can offer a helping hand. The key to this assistance is open communication between adolescent and some significant adult person. Problems may become particularly threatening if communication is lacking at home. Fathers are often busy in more than one job or in pleasurable and social activities and may never have established meaningful communication with their sons. Mothers, either equally busy or bewildered by the complexity of problems and disappointed that the husband doesn't play the role of father adequately, may be unable or unwilling to supply the needs of the adolescent. This may be especially true for the male adolescent who may not want to share his problem with a woman, in whose eyes the woman has not achieved equal status and is still considered educationally and intellectually inferior—a hangover from earlier decades. The female-headed household, so common in the inner-city population, presents this problem frequently and in grave form. Whether the community-centered pediatric and mental health facilities will be able to assist these youngsters will depend to a great extent on whether they will have the support of other agencies, such as the Big Brother League, sports organizations, Scouts, and Recreational Centers with adequate male staffing.

The physician can help by being alert to emotional problems, by an early recognition of self-depreciation, mood swings, periods of depression in the adolescent, and by making himself available for counseling or therapy or by arranging appropriate referrals.

THE MEDICAL PROBLEMS OF THE ADOLESCENT

MATTHEW DEBUSKEY, MD
Associate Professor of Pediatrics
The Johns Hopkins University School of Medicine;
Participating Pediatrician, Adolescent Center
The Sinai Hospital of Baltimore, Inc.

The metamorphosis of youth, transforming the child into a healthy and reasonably adjusted adult, is one of the most critical stages in the natural history of man. This period, adolescence, has focused the concern of societies throughout historical ages and legendary epochs. Initiation rites of ancient as well as contemporary primitive tribes, and the Eleusinian mysteries of the cultured Greeks, attest to the apprehension with which adults viewed the transformation of puberty, and the ceremonial indoctrination with which they enveloped it.

Our own social order has not solved the trials of this transition. The many sociological and technological changes, with which we are still struggling to accommodate, have compelled a prolongation of that interval. No longer is it condensed into a relatively constricted season of sexual maturation, but it extends through the entire teen-age span, and vaguely beyond. Meanwhile, it is generating a force—volatile, impulsive—that from time to time tests the fabric of our own cultural heritage.

The trend in medicine is to emphasize comprehensive care. This concept of the "total" patient assumes a preventative, as well as a therapeutic posture toward both organic and psychological aspects of his well-being. Physicians, despite their physical and treatment orientation are slowly moving in this direction. No one merits this approach more than the adolescent, who so blithely tangles these ingredients with almost impish abandon, and who, in a world of confusion, catapults with coiled power toward a veiled and mobile goal.

Our society is exhibiting a marked and justifiable concern about youth. Fifty percent of our population is under 25 years of age. Approximately 33,000,000 compose the teen-age bracket. Floods of articles, predominantly dealing with psychological dysfunction and social maladaptation, appearing in both popular and professional publications, tax our understanding and fog our judgment. At the meeting of the American Orthopsychiatric Association, 15 meetings referable to adolescence were scheduled; more time than was assigned to any other single topic. Yet with the exception of a few physicians, Gallagher in Boston, Heald in Washington, Johnson in Detroit, and

of a few topics, growth, stature and sexual maturation, there has existed no particularly general effort to explore the variations of organic disorders in the adolescent; nor any concerted attempt to systematically organize this body of knowledge.

At this point, I freely express my belief, that for the individual as well as for the community, the most important single facet, among the many faces of adolescence, is his emotional adjustment. Yet to minimize the organic aspect of his development is negligence, and is unwarranted. What early signals to predictably serious future medical conditions can be identified here? Where are we to focus our efforts for cure or amelioration? What are the most lethal or crippling conditions at this age?

Some clue to the answer of this last question can be obtained from the Vital Statistics published by the U.S. Department of Health, Education and Welfare. Table I lists the figures for 1962.

TABLE I

NATIONAL CENTER HEALTH STATISTICS DEPT. H.E.W.

Deaths In 1962	Total	Male	Female
10-19 YEARS	20,448	13,897	6,551
NON-VIOLENT	10,042		
Neoplasms	2,219		
Cardiovascular Renal	1,297		
1) Vascular Lesions C.N.S.	317		
2) Heart	578		
3) Rheum. Fever & Chronic Rheumatic Heart Disease	279		
4) Chronic Nephritis	266		
Congenital Anomalies	910		
Influenza & Pneumonia	720		
Infectious Diseases Excluding Pneumonia	497		
Diabetes	143		
Asthma	87		
VIOLENT DEATHS	10,426	8,179	2,247
Motor Vehicles	6,278	4,701	1,577
Suicide	658	498	160
Homicide	664	460	204

We notice that violent deaths are more common than non-violent ones. The motor vehicle, by far, is the single largest cause of death. If we are sincere in our determination to reduce adolescent mortality, this might be the area where we exercise whatever influence we possess.

"Reported" suicides almost equal the combined total of rheumatic heart disease, chronic nephritis, diabetes and asthma. If the estimated figure of 1,000 suicides a year occurring among our college students alone, as was proposed by a recent conference of university authorities, is accepted, then it exceeds by far this collected total.

A brief glance at the more recent 1964 statistics is even more depressing. In that year, out of a total of 22,900 deaths, violence provided 13,700; motor vehicles, 7,400; suicide, 743. The three or four to one ratio of male to female is arresting. Why our boy has to prove his virility by killing himself will be a fascinating thesis for future anthropologists. In each of the non-violent categories listed, concentrated effort is being devoted to the study of its development and management. Our big problem in this area is the distribution and provision of service. But these are mortality tables. When we attempt to ascertain morbidity rates and tendencies, we meet with even greater difficulty. There is a paucity of reviews separating adolescents from either children or adults. Yet with the striking changes in biochemical and hormonal systems that occur at this stage, it would be useful to inquire what medical conditions are:

1) initiated (e.g., acne, pregnancy)
2) terminated (m. audouini)
3) potentiated (hypertension)
4) attenuated (petit mal, rheumatic fever)

and why?

However, we might have more information in the years immediately ahead, because very rapidly throughout the country, new clinics are being established for the care of youth. In Baltimore, adolescent services are expanding. Some ten years ago St. Agnes opened an inpatient section, and Sinai simultaneously, an outpatient clinic that has proceeded in a most unexpected and much heralded direction. City, G.B.M.C. and others are allotting bed space for separate units. Hopkins is developing an exemplary training and service program that has earned tremendous intramural popularity. With ideal cooperation, the Department of Medicine and the Department of Pediatrics have assigned an intern, a resident and an attending physician from each service to function simultaneously in this unit, established on C.M.S.C.-9. Introduced in July 1966, it has grown from a small service to a census currently of 18-20 medical patients. It has a very active

educational and recreational program directed by the Child Life Department, and receives patients by referral, by private admission, and from the clinics.

Garell[1] has compiled reports from 225 hospitals, that responded to a circular inquiry.

55 of these have adolescent services,
16 have clinics,
24 have wards,
13 have combined services.

Most of these are small. Some inpatient care is motivated by expediency. The preponderant number of clinics operate one day a week, with an appointment schedule, and rarely see acute or exacerbated chronic ailments. Generalizations from their data are dubious.

However, he has collected the five most frequent diagnoses of emotional disorders, and organic diseases, made in 19 clinics, and has rated them in diminishing order of frequency.

Among **emotional disorders** the first five were:

1) **adjustment reaction to adolescence (10 clinics, the most frequent diagnosis)**
2) **behavior problems**
3) **personality and trait disorders**
4) **psychoneurotic reactions**
5) **scholastic failure**

Each clinic has its own idiosyncrasies in labeling conditions.

Among **organic disorders,** the most frequent were:

1) **obesity (10, most frequent diagnosis)**
2) **acne (1)**
3) **allergy**
4) **seizures**
5) **orthopedic problems**
6) **infectious diseases**
7) **menstrual disorders**
8) **mental retardation**
9) **growth and metabolic disorders**
10) **normal adolescent**

The list, obviously non-representative of a cross-section of adolescent care, with obesity and acne leading the series, and normalcy at the bottom, indicates either referrals from frustrated physicians or problems that tormented the patient himself.

Perhaps a study by Sklar and Downs[2] would be interesting to review. They surveyed all the adolescent diagnoses made by an emergency room service, operating 24 hours a day at a hospital that served a rather stable community of 270,000 people. Teen-agers represented 10% of the population and one-fifth were presumed to use the hospital as its primary medical resource. There occurred 1,172 visits in one year. This formed about 10% of the total registrants.

Accidents and acts of violence produced 51.7% of the total; illnesses and non-traumatic incidents 48.3%. These figures, interestingly, closely resemble the national mortality statistics.

Eighty percent of the visits for surgical services were to treat lacerations, fractures, burns, concussions, etc. Appendicitis was diagnosed 15 times.

Medically, 68% of care was for gastroenteritis and U.R.I. Diagnoses of asthma, hepatitis and communicable disease were rare.

Twelve percent of the ob-gyn problems centered on pregnancy. Six of eight children between 13-16 years had been raped. Menstrual complaints were uncommon.

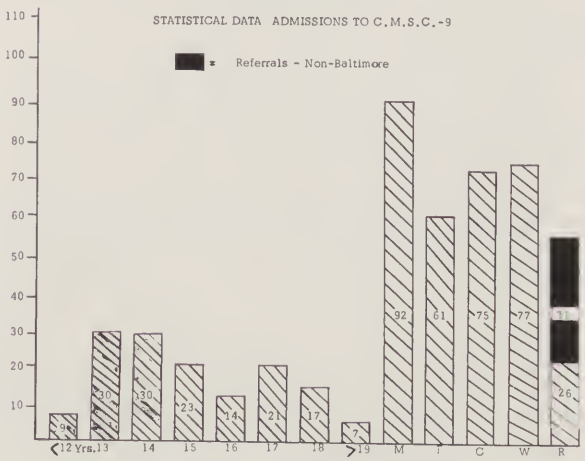
Thirty-three percent of psychiatric patients were suicidal attempts. Only three drug addicts were seen.

Here, obviously, once again the emphasis is on trauma and violence.

Finally, for inpatient care, I have reviewed the case histories of 153 medical patients admitted to the adolescent floor of the Children's Medical and Surgical Center at Hopkins from July 1966 to July 1967.

As you can see from Table II, there were more admissions in the lower age scale. Possibly this group requires more hospitalization. Possibly the generalist and the internist are not yet aware of the existence of this program.

TABLE II

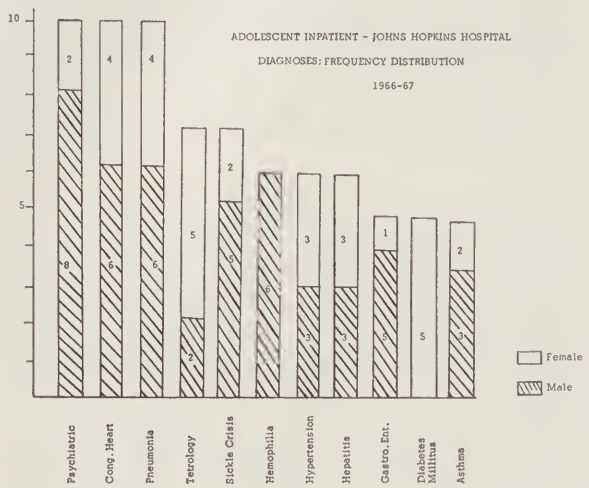


The extreme age levels reveal that there does not exist a compulsive rigidity about limitations to "teens".

Finally, the "R" represents referrals. This would inject a bias in any prevalence figures that could be determined.

Table III rates, in diminishing order, the frequency of diagnostic categories. The psychiatric group was placed first to demonstrate that despite our preliminary intention to avoid admission of emotional problems, these will inevitably appear in any adolescent group, in the guise of conversion, hysteria, psychosomatic and seizure phenomena.

TABLE III



A very active division of cardiology heavily influences the number of congenital hearts as well as that of tetralogy.

Pneumonia was the third item, sharing top position. Surprisingly, most of these were of bacterial origin.

Sickle cell crisis was undiminished. Two of these were of the aplastic variety.

Hemophiliac problems were unabated. It was the 20th admission of one child.

Hypertension should be a fascinating problem to explore at this age. It might be more instructive if we could jettison the magic adult numbers of 140/90. The causes in these patients were well distributed over the entire etiological range: hypoplastic kidney, chronic nephritis, thyrotoxicosis, systemic lupus, coarctation and finally that puzzling state of "labile vascular system."

Masland,[3] in a three-year experience with 1,795 patients, found 25 patients with blood pressure over 140/90. This represented an incidence of 1.4%—only seven of these were organic, three resulting from coarctation.

Hepatitis: two of these were chronic and four acute. One patient had received gamma globulin prophylactically after an exposure two months prior to admission.

Diabetics were admitted because of difficulty in management. One was insulin resistant, requiring over 200 units of insulin for a period of time. This male-female ratio will be interesting to watch.

Two of the asthmatics were particularly handicapped by psychoneurotic states.

Freeman,[4] in an allergic survey of 8th and 12th grade children in Denver, reported that 82% of 130 children, who had asthma as the sole manifestation of atopy before ten years of age, were either improved or well at puberty. Few cases receded after 13 years.

In Table IV, three of the patients with iron deficiency anemia were admitted for other primary conditions. Nevertheless, there has been evidence to suggest that many young college women will exhaust their meager iron stores with one pregnancy. I think many of our adolescents are operating on a tight iron economy.

TABLE IV

**ADOLESCENT INPATIENT—
JOHNS HOPKINS HOSPITAL
DIAGNOSES; FREQUENCY DISTRIBUTION
1966-67**

	TOTAL	M	F
IRON DEFICIENCY	4	1	3
MENINGITIS ASEPTIC	4	3	1
SARCOIDOSIS	4	4	0
RHEUMATIC HEART (1 ACUTE)	4	2	2
BACTERIAL ENDOCARDITIS	2	1	1
SUPRAVENTRICULAR PAROXYSMAL TACHYCARDIA	2	0	2
TUBERCULOSIS	3	1	2
SYPHILIS ACQUIRED (SECONDARY)	2	2	0
SUICIDE ATTEMPT (DRUG)	2	1	1
THYROTOXICOSIS	2	0	2

The pediatricians were surprised to recognize sarcoidosis at such an incidence. These were primarily pulmonary. Two were confirmed by liver biopsy and one by scalene node.

Three of the rheumatic hearts were chronic; only one was acute. This is consistent with the

assumption that acute rheumatic fever declines at puberty.

Tuberculosis is certainly a continuing risk. One patient had pleurisy; one cervical nodes; and one, early dissemination.

Syphilis, acquired, both primary and active secondary stages, is a new disease for pediatricians. Following a post World War II drop in incidence, syphilis is again rising sharply and is occurring with unprecedented frequency in adolescents. One of our patients was admitted as nephrosis. Greater recourse to the VDRL and complete retraction of the foreskin, will net more youngsters in early stages of the disease. The negligence of the physician in reporting these cases, enables contacts, innocently if not naively, to explosively disseminate the infection. This is a serious public health problem.

One suicidal effort was straightforward barbiturate ingestion. The other was dicoumarin and presented quite a bizarre picture.

This last table, Table V, records single cases. I am displaying them because in my own previous experience they are far more important than their low rating here justifies. Some are, by preference, ambulatory problems; others, however, are not; as our total study population rises we will be able to estimate their statistical significance.

TABLE V

ADDITIONAL DIAGNOSES

OBESITY
MIGRAINE
PEPTIC ULCER
ULCERATIVE COLITIS
REGIONAL ENTERITIS
CHOLELITHIASIS
ORTHOSTATIC ALBUMINURIA
METROMENORRHAGIA
DYSMENORRHEA
ATOPIC ECZEMA
EPIPHYSITIS
PSEUDOTUMOR CEREBRI

Obesity, as we observed previously, is a most weighty adolescent problem. With increasing knowledge of lipid metabolism and developing laboratory techniques, we might find some metabolic explanation for this derangement. It is ironic that with undernutrition such a crucial global problem, our major example of malnutrition should be adiposity. I am sure that in many instances, a psychological factor is of cardinal significance.

At this age both migraine and peptic ulcer are ceasing to masquerade in odd garb and are assuming the more characteristic symptom complex of the adult.

We are seeing in children an increasing number of neighboring intestinal conditions, overlapping would be more appropriate, Crohn's disease and ulcerative colitis. Possibly the paucity here might be attributed to our clientele.

Cholelithiasis, not associated with hemoglobinopathy, is rare in childhood, but if we increase our index of suspicion, we'll begin to identify more cases in teen-agers.

The diagnosis of orthostatic albuminuria is diminishing. With kidney biopsies, relatively safe and certainly more common, morphological changes are being reported in this condition; a sanguine attitude might no longer be appropriate.

Gynecological conditions are seen in the gynob clinic and hospitalization, I presume, is made to their own units, unfortunately.

Epiphysitis is not rare, its etiology is controversial, and it is generally out-patient oriented. The child studied had Scheuermann's disease, an involvement of the vertebral bodies.

Pseudotumor cerebri is an uncommon, but not unique, condition of the adolescent girl. It is alarming until diagnosis is confirmed, but then generally responds nicely to active therapy.

This then is a presentation of the organic medical status of adolescence. Each varied approach will produce variations in statistics. Yet in treating an individual child, statistics are not that vital. However, irrefragably, the one most livid fact revealed, is the devastating carnage, in death and mutilation, that violence wreaks among these kids.

REFERENCES

1. Garell, D. C.: Adolescent Medicine: A survey in the United States and Canada, *Am. J. Dis. Child.*, Vol. 109, pages 314-317, April 1965.
2. Harvey S. Sklar and Elinor F. Downs: Acute Medical Needs of Adolescents in an Urban Community: A Survey of Emergency Room Visits, *Clin. Ped.*, Vol. 5, No. 9, pages 560-564, Sept. 1966.
3. Masland, Robert P., Jr., et al.: Hypertensive Vascular Disease in Adolescence, *NEJM*, 255:894-897, Nov. 1956.
4. Freeman, G. L. and Johnson, S.: Allergic Disease in Adolescents, *Am. J. Dis. Child.*, Vol. 107, pages 549-566, June 1964.

This study was supported in part by The Children's Bureau (Special Project No. 132).

I am grateful for the diligent and gracious assistance of Gloria Freeman, pediatric librarian, and Barbara Westmyer, secretary.

A COMPREHENSIVE APPROACH TO OBSTETRICAL PROBLEMS OF ADOLESCENCE

The obstetrical and pediatric departments at Sinai recognized that the adolescent girl with her gynecologic and obstetrical problems benefited from an approach which recognized that she was different. Her gynecological problems were puzzling to her, her pregnancy was more threatening to her, her pregnancy problems more divergent than those of her elders and consequently more severe.

HERBERT L. YOUSEM, MD
Director, Family OB Clinic
Sinai Hospital of Baltimore, Inc.;
Instructor, Obstetrics and Gynecology
The Johns Hopkins University
School of Medicine

LEON GORDIS, MD
Chief, Department of Community Medicine
Sinai Hospital of Baltimore, Inc.;
Assistant Professor of Pediatrics
The Johns Hopkins University
School of Medicine

The development of the primary sex glands and secondary sex characteristics also cast a shadow on feelings and attitudes of the adolescent. The development of these glands results in concentration on specific sexual feelings and activities which differentiate the adolescent from the younger child.

Children who approach adolescence with attitudes and taboos as a result of personal inhibitions and/or environmental rigidity in respect to sex topics are thrown into intense conflict. The resolution of this conflict is generally handled either through direct rebellion against parental and environmental standards or in flight from the reality conflict. Both horns of the dilemma assert themselves and the adolescent either talks through sex, may act through sex, or may flee from the problem by idealizing the opposite sex.

In sharp contrast to the idealized object of sexual fantasy is the stark reality of menstruation, masturbation, and nocturnal emission. Unless reasonably prepared for these natural functions, most children have sharp conflicts about these processes, but the normal adolescent after puberty is able to shift the emphasis from the pure and unadulterated general satisfaction to other aspects of the sex drive which have more points of contact with his total self-interest and goals. The resulting socialization with the same or opposite sex is as a rule associated with a letup in the acute and overwhelming need for masturbation. Little by little the sex life takes its place as one in the mosaic of functions constituting the activity of the person.

The less fortunate child finds greater difficulty in developing a well integrated mode of reaction. The aggressive child runs into social difficulties while the sensitive child withdraws from the

situation into himself. With this process occurring in the adolescent and with approximately 30% of our population being adolescents, is there any surprise to the 1960's being labeled the decade of the sexual revolution?

But something else is happening in the 1960's. Concern about inadequacies in the health and welfare services available to the American public has risen. These considerations prompted the establishment of an Adolescent Center at Sinai Hospital.

A problem of considerable importance amongst adolescents is that of pregnancy. For the past five years over 1000 girls, 14-16 years of age have given birth to live infants each year in the city of Baltimore. Taking into account losses due to spontaneous and induced abortion and fetal death, the number of pregnancies in this age group is considerably higher. Unplanned and undesired juvenile pregnancies thus constitute a serious socio-medical problem for this community and in effect presents a major "chronic illness" of adolescent girls.

In the young adolescent, pregnancy has been variously reported to be associated with higher incidences of toxemias, contracted pelvis, prolonged labor. Among the offspring of such pregnancies there is the excess of prematurity and of neonatal and early childhood death. However little is known of the long-term outcome in regard to later morbidity of the offspring of the adolescent mother. In addition the question may be raised as to the adequacy of the mother-child relationship which develops when the mother is of such a young age.

A significant educational liability commonly results from adolescent pregnancies. In most urban areas pregnancy represents an abrupt end to the young person's education. Although in many instances she is permitted to return to school after delivery, very often problems of care of the infant as well as the basic difficulty of adjustment prevent her from actually continuing her education. Although in cities such as Baltimore the establishment of schools for pregnant teenagers has tended to improve the situation, the problem has by no means been eliminated. Termination of a girl's schooling all too often represents the end of her vocational training as well. In many instances such girls become permanently dependent upon public assistance.

Once a teen-ager has had an illegitimate child there is a strong likelihood that she will have one or more other illegitimate children within the next several years. In essence, these girls continue to repeat a cyclical pattern from one generation to the next of dependence upon public support and of pregnancy at a very young age. The likelihood of their becoming self-supporting or of moving up the socio-economic scale is indeed slim.

In our experience, the pregnant teen-ager frequently has an unrealistic hope that the putative father will marry her. All too often however, teen-age illegitimate pregnancy represents the beginning of a one-parent family. When marriage does result it is frequently of an unstable nature and it has been observed that two to three out of every four teen-age marriages end in divorce.

As a result of these significant obstetrical and neonatal problems, as well as the serious social and educational difficulties associated with adolescent pregnancy, a Family OB Clinic was instituted at the Sinai Hospital Adolescent Center. Here the chief residents in the specialty, an attending physician, a social worker, and a public health nurse join forces in this special clinic to try to minimize these problems by providing the pregnant adolescent with prenatal care and later with postpartum care and birth control.

These patients meet in a special night clinic where all the patients are their own age and facing similar problems. There are no adult patients in the environment. A more personal approach to the problem is effected because of the stability of the clinic personnel. The chief resident acts as her clinic physician as well as her hospital physician at the time of labor and delivery whenever feasible. In this manner a closer doctor-patient relationship develops with a freer exchange of communication between the two. Problems are more easily brought up and discussed by the adolescent with the physician. The public health nurse is involved with the patient during the clinic sessions, at the patient's home both before and after delivery, as well as while the patient is in the hospital. Likewise the social worker is involved with the patient from the first visit in attempting to solve the multiple social problems such as school, marriage, support, physical facilities for the baby, etc.

All are basically geared towards solving the special medical problems involved, towards keeping the patient in school during and after the

pregnancy, and of assuring adequate neonatal and pediatric care to the newborn.

Data from this program is still being analyzed. It is hoped that this multi-disciplined approach will have results comparable to those of Yale and Syracuse where the children did return to school, did bring their babies back to the doctor for care, and did show improvements in toxemia rates, cesarean section rates, and in general seemed to fare much better as a result of this type of plan.

However, regardless of how well motivated and sensitive the services for pregnant teen-agers are, many of the tragic consequences of unplanned and undesired pregnancies in the adolescent cannot be prevented. These problems therefore warrant an attempt at primary prevention of adolescent pregnancy. It is a reality of the present-day situation that in many instances moral teaching and parental sanction are not sufficient to prevent teen-agers from engaging in sexual activity. With this realization therefore the provision of birth control information and services on a limited and selected scale were instituted at the Sinai Adolescent Center in a special program known as the Adolescent Family Life Service. This service provides birth control information and service for sexually active nulliparous teen-agers with the consent of the teen-ager and her parents.

This clinic is manned by a pediatrician, gynecologist, social worker, and public health nurse. Their services are supplemented by those of a clinical psychologist and psychiatrist when indicated. The patients are referred to the clinic primarily by the public health nurses and social workers in the field and from various community agencies. At the time of referral, the adolescent and her parents have individual screening interviews. If mutually agreeing, the child is then seen in the Adolescent Center per se where a complete history, physical, and laboratory workup are performed. Appropriate contraception is then dispensed and a close followup of the patient is made by means of frequent clinic visits and public health nurse home visits.

During clinic visits the girl participates in group discussions about any topic the group elects to talk about that night, such as parental relationships, school problems, sex, pregnancy, boys, etc.

In our first year, 93 girls were screened and only 62 accepted by the clinic. Of these, 43 have been placed on contraception and 30 of them have been maintained on contraception for more than one year with no pregnancies resulting. The remaining children have been referred to various counseling services, specialty clinics, or other resources. As you can see, the numbers are too small to evaluate the effectiveness of this program but we are continuing to collect relevant data as our clinic grows.

It nonetheless should be clear that premarital pregnancies cannot be controlled by devices alone. Clearly, attitudes have to change also. Many females cannot use a diaphragm or take the pill because they do not conceive of themselves as always being prepared for coitus. They must be emotionally carried away for intercourse to occur. Such a self-image is permanent and blocks the use of many contraceptive devices. A fuller solution to the problems requires a deeper attitudinal change regarding the acceptability or non-acceptability of premarital coitus. It is in this area that the close doctor-patient relationship, the nurse-patient relationship, the social worker-patient relationship which exists in this clinic has its bearing on the problem. Likewise the group discussion sessions assist in developing these attitudes.

A major problem has arisen in these sessions with dealing with family-life teaching and sex education. It has proven difficult to find suitable audiovisual material and other teaching aids for low socio-economic groups particularly among the non-white adolescents. There is an urgent need for developing appropriate material in this area.

Some fear that this program may encourage promiscuity. One may question this latter view because the available evidence indicates that it is one's basic values and the pressure of the situation that actually determine whether intercourse takes place. The knowledge and availability of effective contraception may be a minor factor in such a decision but it would rarely be a determining force. The best contraceptively informed youths are not necessarily the most permissive.

In summary, we have described the adolescent period as a turbulent one. Medical concern about this age group is rising. Obstetrics and gynecology together with pediatrics has an intimate role to play in resolving these problems.

References will be supplied upon request.

your medical faculty at work

by John Sargeant
Executive Secretary

The Council met on November 14, 1968, and took the following actions:

1. Adopted financial statements, both operating and dedicated fund, through September 30, 1968.
2. Approved recommendations for Emeritus Membership from component societies to be submitted to the House of Delegates.
3. Approved an increase in financial aid to the family of an ill physician; and approved refunding 1968 dues to the same family.
4. Approved installation of protective grillwork for the History of Medicine collection in the library.
5. Adopted a School Health Examination Form, with the urgent request that emphasis be placed on the completion of Part I of the form by parents before requesting the physician to complete Part II.
6. Adopted 1969 Council meeting dates.
7. Presented a second Viet Nam plaque to Louis Padovano, MD, of Woodstock, Md.
8. Authorized employment of legal counsel for 1969.
9. Authorized the writing of a letter requesting active Faculty participation as a full partner in the Regional Medical Program.
10. Ratified various legal defense cases.
11. Declined with regret the granting of legal defense in one case because of late payment of dues.
12. Heard of the conclusion of various legal defense cases.
13. Directed the Faculty office to ascertain if malpractice insurers would pay "punitive" damages if awarded in professional liability cases.
14. Authorized changing the location of the 1969 Semiannual meeting to Hershey, Pa.
15. Authorized continued discussions by a special Ad Hoc Committee in connection with a proposed Multiphasic Screening program.

ETHICS CORNER

Use of Credit Cards

From time to time, the Faculty Office receives requests for information with respect to physicians utilizing the services of Credit Card Companies. Recently, the Bank America Credit Card group raised the question as to the ethics of use of their cards by physicians.

The Judicial Council of the American Medical Association has repeatedly stated that the use of such cards is unethical.

This question was originally considered by the Faculty in 1963 when Central Charge Service of Washington, DC, indicated its wish to offer this service to physicians in the DC area. At that time the Faculty's Council stated:

> **"The Council finds this not in the best interest of the patient-physician relationship and it therefore does not give its approval . . ."**

The Judicial Council of the AMA, following an appeal of the Faculty's decision on the Central Charge Service, ruled:

> **"The Judicial Council of the AMA looks with disfavor on the use of the service of the Central Charge-it Company and similar operations . . . because of the implication of advertising and patient solicitation. Further, the council does not believe that these kind of plans uphold the dignity and honor of the profession."**

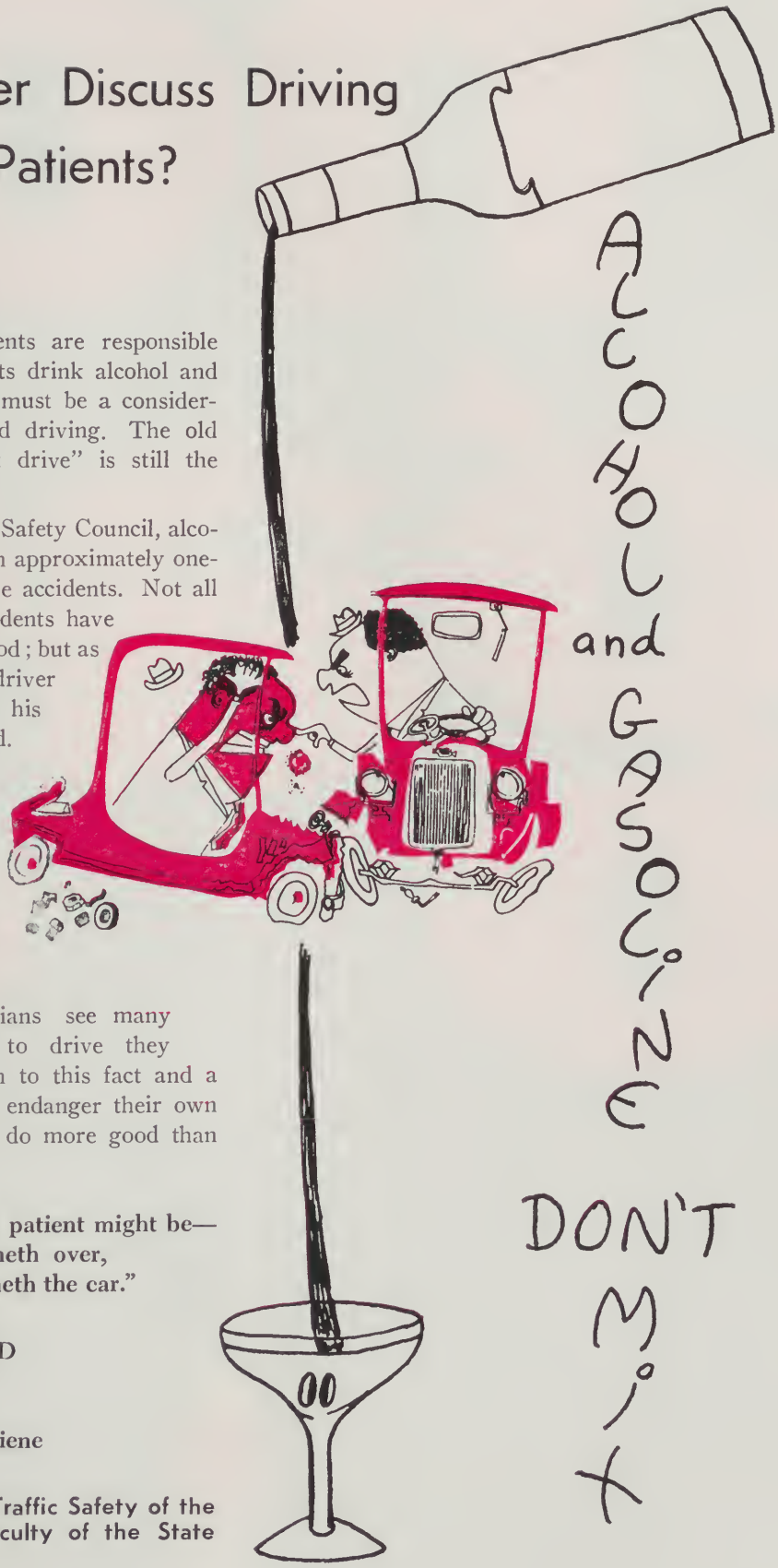
Charge Plans should not be confused with "billing services" offered by some groups in Maryland. They should not be confused with "discounting" services offered by other groups.

In essence, these questions should be asked when giving consideration to any type of commercial service offered the physician:

- ☐ Does the use of this service increase, in any way, the cost of medical care to the patient?
- ☐ Does the service interfere with the physician/patient relationship?
- ☐ Are physician's bills rendered in the physician's name and not in the name of the service?
- ☐ Does the physician lose control of the bill and the manner in which it may be collected?
- ☐ Does the display and publication of physicians' names as participants in the program constitute advertising?
- ☐ How does this activity affect the patient's considerations? Does it downgrade the physician's image as being interested only in financial return?
- ☐ How are third-party payments handled? Is the patient entitled to service benefits under his insurance program?



Doctor,
Do You Ever Discuss Driving With Your Patients?



The majority of your patients are responsible people. However, most adults drink alcohol and most adults drive and there must be a considerable overlap of drinking and driving. The old motto, "If you drink—don't drive" is still the best advice.

According to the National Safety Council, alcohol is a leading factor in approximately one-half of the fatal motor vehicle accidents. Not all drivers involved in fatal accidents have high alcohol levels in their blood; but as the percentage increases the driver becomes more cocky and his judgment becomes impaired. In other words, the effect of alcohol on drivers is both physical and psychological. The combination of drugs and alcohol may be particularly dangerous when each re-enforce the effect of the other.

It is obvious that physicians see many patients whose ability to drive they question. A frank discussion to this fact and a statement that they not only endanger their own life, but that of others, may do more good than any proposed legislation.

A parting suggestion to your patient might be—
"If your cup runneth over,
let someone else runneth the car."

IRENE L. HITCHMAN, MD
Director of Hospital
Inspection and Licensure
Department of Mental Hygiene

From the Subcommittee on Traffic Safety of the Medical and Chirurgical Faculty of the State of Maryland

no gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

case you're curious, back in the 1700's paregoric was ing used for diarrhea, but since the state of the pharma- utical art was extremely primitive, fungus growth in e medication was a problem. Bitter-tasting camphor as added to prevent such growth and anise oil was lded in an attempt to cover up the camphor taste. IA-quel Liquid is a modern formulation that does not ntain either of these outdated ingredients.

aution: With use of DIA-quel Liquid observe the usual recautions associated with opium derivatives and anti- holinergics.

osage: Usual adult dosage: 1 or 2 tablespoonfuls (15 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's ule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

ow Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID

IPC
REG. U.S. PAT. OFF.

INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Maryland's Privately Operated Psychiatric Hospitals*

Nearly 15% of all psychiatric inpatient admissions in Maryland last year were to the seven privately operated hospitals although these provide 8% of available beds. A slightly larger number were reported to the Psychiatric Case Register as having been admitted to the Veterans Hospital at Perry Point and to other units not administered by the Department. The remaining 70% were to the six state psychiatric hospitals. Patient movement data for the year ending June 30, 1967 are summarized in the following table.

TYPE OF FACILITY	*RES. PATIENT POPULATION 7-1-66*	*ADMISSIONS DURING YEAR***	*DISCHARGES DURING YEAR***	*DEATHS DURING YEAR*	*RES. PATIENT POPULATION 6-30-67*
D.M.H. OPERATED	8,178	11,091	10,439	859	7,652
PRIVATELY OPERATED ...	869	2,284	2,281	33	839
OTHER INPATIENT***	1,635	2,757	2,667	57	1,668
TOTAL	10,682	16,132	15,387	949	10,159

Proportionally, Maryland has always had a substantial segment of its psychiatric patient population treated in privately operated facilities. One of these, the Seton Institute, has been in continuous existence since 1840. It is mentioned by Albert Deutsch in his book "The Mentally Ill In America" as the oldest religiously affiliated psychiatric hospital in the United States. Its history of service is exceeded in this state only by the Spring Grove State Hospital. In Maryland, as throughout the United States, the number of private hospitals has declined in recent years because of personnel shortages, rising costs and other related problems. However, since many of the remaining hospitals have increased their bed capacity, they have maintained their proportion of the total caseload.

Traditionally, the relatively high cost of hospital care in private facilities has produced a patient population with an excess of individuals having the following characteristics: white, female, in the middle years of life (25-54), middle and upper-middle class admitted for the short-term treatment of acute psychoneurotic reactions and personality disorders. Negroes, alcoholics, the senile and chronically ill appeared relatively infrequent. In more recent years the inclusion of psychiatric care in health insurance programs has broadened this population pool. At the same time, tranquilizing drugs, improved standards and the development of new treatment concepts and services have produced major changes in patterns of hospitalization, retention and release of state hospital patients.

Thus, individuals entering public or private psychiatric hospitals are now somewhat more comparable than they have been in past years. The quality and type of services received during hospitalization has also become more similar. Continuation of this trend should produce greater coordination of programs and result in better psychiatric services for all population segments.

* Brook Lane Center, Chestnut Lodge, Gundry Sanitarium, Seton Institute, Sheppard Pratt, Taylor Manor and Washington Sanitarium.

** Does not include placements on or returns from long-term leave.

*** One county operated, one V.A. and three psychiatric units of general hospitals.



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Prediction of Performance of Patients With Hip Fracture

"One concern of the writer in the course of reevaluating his own views by tracing current conflicts of doctrine to their sources has been to remedy an increasingly widespread disposition of the younger generation of research workers to relinquish the obligation to examine the credentials of principles invoked in the day's work."

Lancelot Hogben in "Statistical Theory".

* * * * *

In previous publications,[1] a method for collecting data on patients referred to a Department of Physical Medicine and Rehabilitation was outlined. The method is based on the assumption that future performance can be predicted from initial information collected in three areas: ● the diagnosis, ● the activities of daily living (ADL) and ● the degree of orientation (MSCL). In each of these three areas, an ordinal scale has been defined. In Rehabilitation Notes to follow, we will discuss the rehabilitation of patients with specific diagnoses.

No therapeutic procedure is to be followed blindly without careful evaluation of the patients' whole background, attitude and response. Pragmatism, modification, expediency, opportunism, and utility are the sheet anchors of rehabilitation.

We shall, therefore, be particularly concerned with prediction of performance and evaluation of results.

Material and Methods

A group of 183 patients with 185 hip fractures (2 patients fractured each hip at different times) was analyzed. Thirty-five patients had Austin-Moore prostheses inserted and are not considered further in this paper. All types of hip fractures in patients over 15 years of age were included.

Patients were followed in the Department of Physical Medicine and Rehabilitation until they were judged to have reached maximal physical therapy benefit or until they died. Those who reached full independence early were discharged early; those who needed continued physical therapy or medical treatment remained in the hospital until they had reached maximal hospital benefit.

The great majority of patients were seen within a few months of the hip fracture, and weight bearing was not allowed. This report, therefore, is concerned mainly with performance of the patients in early (non-weight bearing) period of convalescence. Those who reached independence in ambulation and stair climbing did so with the help of crutches or a walker. We do not have data on the final performance status of these patients after they had been allowed full weight bearing.

Results

Table 1 is a summary of the findings at initial evaluation plotted against the outcome during the first six months of treatment in the Department of Physical Medicine and Rehabilitation. Results of treatment are judged purely on whether the ADL score increased from a lower ADL score group to 100 (full independence, column 1),

reached a score of 90 to 99 (column 2), improved significantly (defined as reaching any higher ADL score group, column 3), remained unchanged (defined as no change in ADL score group, column 4), or deteriorated (defined as dying or falling into a lower ADL score group, column 5). These are mutually exclusive categories.[1]

It will be noted that 103 (columns 1, 2, and 3) of the 150 patients showed significant improvement in ADL score; 76 (columns 1 and 2) reached a score above 90 and 43 (column 1) reached a score of 100 (full independence in ADL). Twenty-six (column 4) patients showed no significant change in ADL score and 21 (column 5) deteriorated in ADL score and/or died.

Factors on the initial visit associated with improvement in ADL score

The major purpose of this paper is to identify those factors noted on initial evaluation which are associated with improvement in function. One would like to be able to predict which patients will benefit from treatment and which will not.

TABLE 1

RESULTS OF TREATMENT

Summary of findings at initial visit with subsequent results of treatment in 150 patients with hip fractures		Total Cases	1 Reached full Independence: ADL Score 100	2 Reached ADL Score 90-99	3 Reached ADL Score Less Than 90	4 Unchanged ADL Score	5 Deteriorated in ADL Score or Died	Column
Cases:		150	29*	22*	18*	17*	14*	
Categories:								
Age	59 or younger	40	65	17	13	2.5	2.5	
	60-69	27	15	48	22	15	0	
	70-79	50	20	22	20	14	24	
	80+	33	9	6	18	43	24	
Sex	Male	64	36	23	16	6	19	
	Female	86	23	21	20	26	10	
Duration at Initial Visit	1 week or less	37	31	32	22	5	11	
	1 week to 1 month	72	29	25	19	19	8	
	1 month to 6 months	33	31	6	9	21	33	
	6 months to 1 year	4	25	0	50	25	0	
	1 year or more	4	25	25	0	50	0	
Medical Prognosis	Normal Life Span	66	32	27	18	15	8	
	Reduced Life Span	84	26	18	18	19	19	
Initial MSCL Score	0-10	13	0	8	15	54	23	
	11-20	23	0	17	22	26	35	
	21-30	21	14	14	19	34	19	
	31-40	35	34	20	23	14	9	
	41-50	55	50	31	15	2	4	
Initial ADL Score	0-20	26	4	14	12	35	35	
	21-40	51	19	18	29	18	16	
	41-60	59	41	29	15	10	5	
	61-80	8	37	37	0	13	13	
	81-95	5	100	0	0	0	0	
	95-100	1	0	0	0	100	0	
Diagnostic Group	1	60	33	30	15	15	7	
	2	19	48	31	5	11	5	
	3	71	20	13	24	20	23	

* Numbers are percentages of the numbers in the Total Column.

Although prediction can never be entirely accurate, the method outlined herein should be superior to pure clinical impression. Furthermore, the patients who are expected to do poorly may benefit from special measures taken early.

AGE: It is clear from the study of Table 1, that age is an important factor in improvement in ADL score. This conclusion is supported by three related observations. First, patients who reached full independence (column 1) contained the largest per cent (65%) of the youngest age group—40. Secondly, patients under 59 constitute the largest number, 26, of all those who reached full independence, 43. Thirdly, comparing the different ages of patients in the different final ADL score group (columns 1 to 5), there is a tendency for the percentage of elderly patients to increase in age as their final independence category (as measured by ADL score) decreases. Thus 60% of those who reached full independence (column 1) were under 59. Among those who deteriorated or died (column 5), 95% were over 70.

SEX: Table 1 suggests that men were more likely to improve than women. This is supported by the higher per cent of men than women in column 1, and the fact that 52% of all those who reached full independence were men, although there were fewer men than women in the total series. However, it is noteworthy (column 5) that more men than women deteriorated both proportionally and absolutely. Thus the men were less likely to remain stable in performance (column 4); they tended either to improve or deteriorate, while the women were more likely to remain unchanged (column 4).

DURATION: Surprisingly, the duration of the hip fracture at the time the patient was first seen in the Department of Physical Medicine and Rehabilitation did not seem to be of overriding importance as far as future performance was concerned. The number of patients who had fractures for longer than six months (groups 4 and 5) is too small to be conclusive. If all patients with duration less than one week are compared in columns 1 to 5, it appears that patients with a very short duration (one week or less) are more likely to show improvement (columns 1, 2 and 3) than to remain unchanged or deteriorate (columns 4 and 5).

MEDICAL PROGNOSIS: Patients with a good medical prognosis (normal life span) appear to be slightly more likely to reach full independence than those who have poor life prognosis. Furthermore, three times as many patients with a poor life prognosis deteriorated (column 5) than those with a normal prognosis for life.

MSCL SCORE: An initial MSCL score above 30 was present in 91% of the patients who subsequently improved. The MSCL score was below 30 in 72% of the patients who deteriorated or died. The higher the MSCL scores the greater the likelihood of improvement.

ADL SCORE: There were few patients in ADL score groups 81-95 and 96-100. ADL score group 41-60 contained the largest proportion of patients who ended up fully independent. The greatest number of those reaching full independence came from this group. As final independence decreased (columns 1 to 5), the initial ADL scores tended to be lower.

DIAGNOSTIC GROUP: Diagnostic Group 1 includes patients with no other disease or impairment than a fractured hip. Diagnostic Group 2 includes those with hip fractures who have in addition another disease but no added impairment. Diagnostic Group 3 is made up of patients with hip fractures and additional manifested diseases or impairments. Table 1 reveals little difference in prognosis for performance between Diagnostic Group 1 and 2, but both of these Groups end up with higher performance than Group 3. Table 2 shows diseases and impairments associated with the hip fracture in Diagnostic Groups 2 and 3.[2, 3]

(See page 70 for Table 2)

Discussion

A method has been developed to estimate the rehabilitation needs and potential of patients when first seen in a Department of Physical Medicine and Rehabilitation. The method requires evaluation of the patient from the diagnostic and functional (physical and mental performance) point of view using semi-quantitative ordinal scale grading.

This evaluation method has been applied to 150 patients with hip fractures to compare the actual results of treatment with the original evaluation measurements. It is possible to identify those original measurements associated with later improvement or deterioration.

It is obvious that the patients in this study are generally elderly and many have multiple diseases, have physical impairments other than those

TABLE 2

Major diseases and/or impairments associated with hip fracture in Groups 2 and 3.

Major Diagnosis in addition to hip fracture	Diagnostic Group 2	Diagnostic Group 3
1. Heart Disease, never decompensated	8	
2. Alcoholism, chronic	4	2 (with) cerebellar ataxia)
3. Diabetes Mellitus	2	1
4. Hypertension	1	
5. Obesity	1	2
6. Deaf	1	
7. Pernicious Anemia	1	
8. Recent Gastrointestinal bleeding, surgery or ulcer	1	3
9. Hemiplegia		16
10. Heart disease with decompensation in past		15
11. Fracture elsewhere		8
12. Chronic Obstructive Lung Disease		6
13. Partial to Total Blindness		5
14. Neoplasm with metastases		4
15. Severe Depression		1
16. Rheumatoid Arthritis		1
17. Parkinson's Disease		1
18. Pulmonary Tuberculosis		1
19. Amputation		1
20. Old severe poliomyelitis		1
21. Muscle Atrophy		1
22. Unexplained dizziness		1

resulting from the hip fracture, and a high incidence of mental difficulties. This selection of patients mirrors the hospital population of elderly Welfare patients. Furthermore, patients who were able to master crutch walking easily were often discharged from the hospital without referral to the Department of Physical Medicine and Rehabilitation.

Because of small numbers and ordinal type scales used in evaluation, rigorous statistical methods cannot be applied to the material collected. It is, however, possible to identify certain features found at initial evaluation which are favorable or unfavorable for future improvement in physical function.

A Prognostic Index

Schnur [4] and Peel [5] developed prognostic indices for patients with acute myocardial infarctions. By scoring different historical features and physical findings at admission, they have been able to correlate the initial score with mortality rate during hospitalization. We have attempted to develop such a prognostic index, not for mortality but for physical performance. The question asked at the initial evaluation is whether the patient can benefit from treatment in the Department of Physical Medicine and Rehabilitation. Thus we are interested in treating not just those patients who can reach high levels of independence, but all who can benefit at all from treatment.

Table 3 shows a prognostic index derived by trial and error for the prediction of future performance (as measured by the ADL score).

TABLE 3

Tentative Prognostic Index in patients with hip fracture.

Item	Score
SEX: Female	1
AGE: 60-69	1
AGE: 70-79	2
80+	3
Duration: Greater than 1 month	1
Initial MSCL Score 0 to 10	5
Initial MSCL Score 11 to 20	3
Initial MSCL Score 21 to 30	1
Initial ADL Score 0 to 20	3
Initial ADL Score 21 to 30	2
Initial ADL Score 31 to 40	1
Medical Prognosis: Decreased life expectance	1
Diagnostic Group 3.	2
Worst Score	15

Table 4 shows the application of the prognostic score to the 147 cases of hip fracture in whom the initial data was complete. The largest number of cases have low prognostic indices. All patients with 0 prognostic index reached full independence, and as the prognostic index increased, the patient was less likely to improve in ADL score until with a very high prognostic index there were no cases which improved in performance. Ninety-six percent of the patients with prognostic indices of 4 or less showed some improvement in ADL score. Only 46% of those with indices greater than 4 improved and fewer reached high degrees of independence in ADL.

It must be emphasized that the prognostic index is derived from a small number of highly selected

TABLE 4.

Tentative Prognostic Score and Final Outcome.

Prognostic Score Calculated at Initial Evaluation	Total Cases	Reached Full Independence ADL Score 100	Reached ADL Score 90-99	Reached ADL Score less than 90	Unchanged ADL Score	Deteriorated or Died
0	2	2 (100%)				
1	16	11 (69%)	5 (31%)			
2	11	5 (45%)	5 (45%)	1 (10%)		
3	18	8 (44%)	6 (33%)	2 (11.5%)	2 (11.5%)	
4	20	9 (45%)	5 (25%)	5 (25%)	1 (5%)	
5	12	2 (17%)	2 (17%)	4 (33%)	1 (8%)	3 (25%)
6	14	1 (7.5%)	1 (7.5%)	6 (43%)	3 (21%)	3 (21%)
7	9	3 (34%)	2 (22%)	2 (22%)	2 (22%)	
8	7	1 (14%)	1 (14%)	2 (28.5%)	1 (14%)	2 (28.5%)
9	7			2 (28%)	2 (28%)	3 (44%)
10	7		1 (14%)	1 (14%)	2 (28%)	3 (44%)
11	5			2 (40%)	3 (60%)	
12	8		1 (12.5%)	2 (25%)	4 (50%)	1 (12.5%)
13	6		1 (17%)		1 (17%)	4 (66%)
14						
15	5				3 (60%)	2 (40%)
Total	147	42	30	29	25	21

cases and is meant only as a supplement to clinical impression. It is, however, a step toward identifying factors of importance in regaining physical independence after a hip fracture.

The Natural History of Hip Fracture

The majority of patients in this study had physical and mental limitations not directly attributed to the hip fracture. What are some of the factors which explain poor physical and mental performance in patients with hip fracture?

■ Selection of Cases: It has been pointed out that the Baltimore City Hospitals tends to accumulate patients with multiple chronic diseases and major social problems. The patients who perform well following surgery for hip fracture are discharged home and may never be seen by the Department of Physical Medicine and Rehabilitation.

■ Inactivity: It is our impression from the history and from the examination of feet for calluses, that the majority of patients who suffer hip fractures have been inactive for a prolonged period prior to the fracture. There has already been a general decline in physical and mental activity in many of our patients before they suffer a hip fracture.

■ Associated Diseases or Impairments: It was pointed out above that patients placed in Diagnostic Group 1 generally had only one manifested physical impairment, *ie,* hip fracture. Some of these manifested evidence of "Chronic Brain Syndrome". Others had subclinical diseases which might not be identified during hospitalization. Table 2 shows some of the diseases associated with Diagnostic Group 2 (unmanifested in terms of performance) and Diagnostic Group 3 (symptomatic).

■ The Hip Fracture: The actual fracture of the hip often proves to the patient that he is no longer capable of walking safely. It then may be very difficult to persuade him that he should even try to walk again.

■ Mentational Status: Thirty-eight per cent of the patients had MSCL scores of 30 or less, indicating moderate to severe mental deficits. These low MSCL scores are the result of a number of factors. The patients seen in this hospital come from the lowest economic and educational group. After retirement, with the decrease in physical activity, there may be an associated emotional withdrawal. A number of patients had symptoms suggestive of intermittent cerebral ischemia as well as frank atherosclerosis. Some had no abnormality on general history and physical examination, but had very low MSCL scores suggestive of "Chronic Brain Syndrome".

Hospitalization itself may have a deleterious effect on patients in borderline mental compensation. The new environment, anesthesia, confinement to bed, various medications, the separation from familiar surroundings and people, may all contribute to disorientation and depression particularly in elderly patients with limited range of mental adaptability.

In brief, fracture of a hip often does not occur by chance. It is a symptom of the physical and mental deterioration which occurs commonly as a result of aging and multiple diseases.

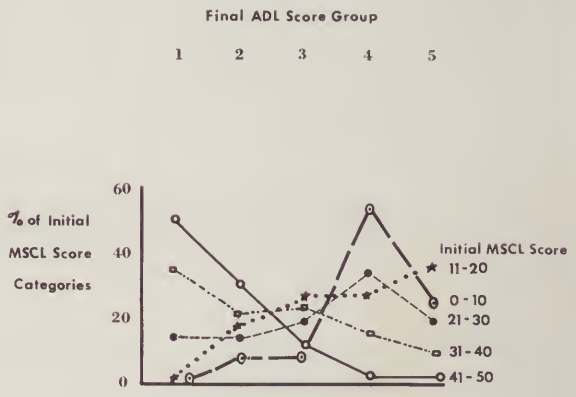
Summary

One hundred fifty cases of hip fracture of all types have been studied in an attempt to identfy what features of the patient's situation seen at initial evaluation are of importance in prognosis for performance of activities of daily living. A prognostic index helpful in predicting final ADL score has been derived. Initial evaluation of physical and mental function are the most important initial findings on which to base prognosis for physical performance.

Addendum

The weight to be given to each initial finding in estimating the Prognostic Index can be demonstrated in Graph 1. This graph is made directly from Table 1. It adds no new data, but possibly the graph allows easier visualization of the relationships. On the ordinate is the percent of patients in each initial MSCL score group who end up finally in each of the five final ADL score groups (abscessa). Thus of the initial MSCL score group 0 to 10, 0% ended in Column 1, 8% in Column 2, 15% in Column 3, 54% in Column 4 and 23% in Column 5. This MSCL score group had none of its original members end up in Column 1. Thus we assign a value of 1 point against this MSCL score group because none of its members reached full independence. If we look at the other columns, we see that there is in addition a tendency for patients in initial MSCL group 0-10 to fall into the poorer final ADL score groups. This tendency re-enforces our impression of poor performance, and we add a second point against this group.

GRAPH 1



If we now compare the trends of the different MSCL groups in Graph 1, we see that they not only tend to arrange themselves in order of descending percentage in Column 1 but do the reciprocal in Columns 4 and 5. Thus there is a very strong, regularly shifting relationship between initial MSCL score and final ADL score group. Therefore we give a maximum value of 5 points against the lowest MSCL score group.

REFERENCES

1. Carroll, D.: Rehabilitation Notes. *Maryland State Med. J.*, Vol. 17, Nos. 5-12, 1968.
2. Katz, S., Heiple, K. G., Downs, T. D., Ford, A. and Scott, P.: Long term course of 147 patients with fracture of the hip. *Surg., Gynec., and Obst.* 124: 1219, 1967.
3. Furey, J. Genge: Complications following hip fractures. *J. Chron. Dis.* 20: 103, 1967.
4. Schnur, S.: Mortality Rates in Acute Myocardial Infarctions. II A Proposed method for measuring quantitatively severity of illness on admission to the Hospital. *Ann. Int., Med.* 39: 1018, 1953.
5. Peel, A. A. F., Semple, T., Wang, I., Lancaster, W. M. and Doll, J. L. G.: A Coronary Prognostic Index for Grading the Severity of Infarction. *Brit. Ht. J.* 24: 745, 1962.

once-popular treatment for back pains
is to have the seventh son of a seventh son
and or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

or headache, a sovereign remedy was
wear a snakeskin round one's head.



A realistic approach to pain relief



Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

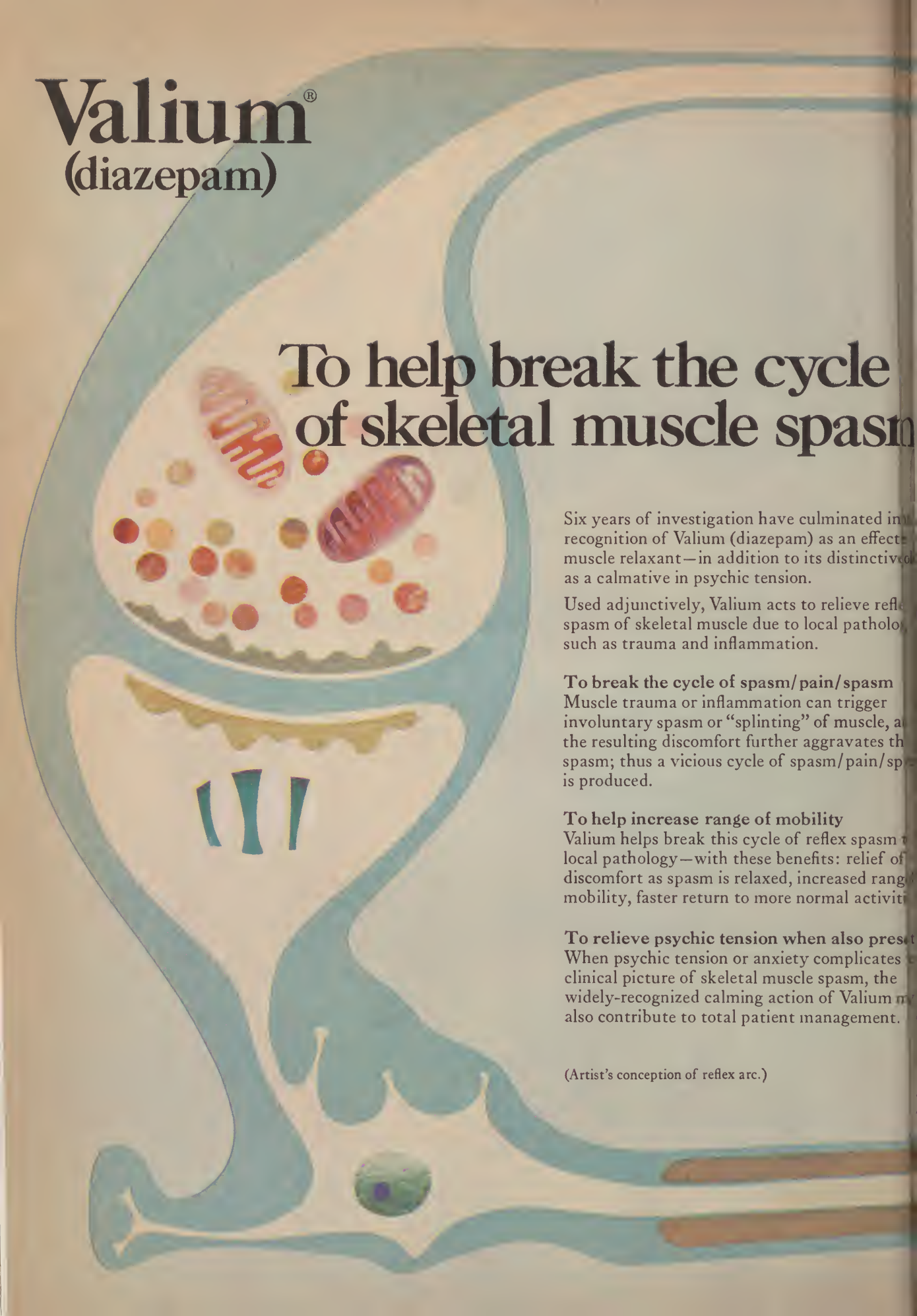
Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—
May be habit forming), Phenacetin gr. 2 1/2,
Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

B.W. & Co.' narcotic products are
Class "B", and as such are available on oral
prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Valium®
(diazepam)



To help break the cycle of skeletal muscle spasm

Six years of investigation have culminated in
recognition of Valium (diazepam) as an effect
muscle relaxant—in addition to its distinctive
as a calmative in psychic tension.

Used adjunctively, Valium acts to relieve refle
spasm of skeletal muscle due to local patholo
such as trauma and inflammation.

To break the cycle of spasm/pain/spasm
Muscle trauma or inflammation can trigger
involuntary spasm or "splinting" of muscle, a
the resulting discomfort further aggravates th
spasm; thus a vicious cycle of spasm/pain/sp
is produced.

To help increase range of mobility
Valium helps break this cycle of reflex spasm
local pathology—with these benefits: relief of
discomfort as spasm is relaxed, increased rang
mobility, faster return to more normal activit

To relieve psychic tension when also pres
When psychic tension or anxiety complicates
clinical picture of skeletal muscle spasm, the
widely-recognized calming action of Valium m
also contribute to total patient management.

(Artist's conception of reflex arc.)



ore prescribing, please consult complete
duct information, a summary of which follows:

ications: Tension and anxiety states; somatic
nplaints which are concomitants of emotional
ors; psychoneurotic states manifested by
sion, anxiety, apprehension, fatigue, depressive
nptoms or agitation; acute agitation, tremor,
rium tremens and hallucinosis due to acute
ohol withdrawal; adjunctively in skeletal
scle spasm due to reflex spasm to local
hology, spasticity caused by upper motor
ron disorders, athetosis, stiff-man syndrome,
vulsive disorders (not for sole therapy).

ntraindicated: Known hypersensitivity to the
g. Children under 6 months of age. Acute
row angle glaucoma.

rnings: Not of value in psychotic patients.
ution against hazardous occupations requiring
nplete mental alertness. When used adjunctively
convulsive disorders, possibility of increase in
quency and/or severity of grand mal seizures
y require increased dosage of standard anti-
vulsant medication; abrupt withdrawal may
associated with temporary increase in frequency
l/or severity of seizures. Advise against
ultaneous ingestion of alcohol and other CNS
pressants. Withdrawal symptoms have
urred following abrupt discontinuance. Keep
diction-prone individuals under careful
veillance because of their predisposition to
bituation and dependence. In pregnancy,
tation or women of childbearing age, weigh
tential benefit against possible hazard.

ecautions: If combined with other psycho-
tropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, or 10-mg tablets, t.i.d. or q.i.d. and when skeletal muscle spasm and psychic tension interfere with sleep: add 1 tablet, h.s., to t.i.d. dosage

ROCHE

Roche®
LABORATORIES
Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110

Public Enema No.





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

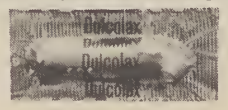
Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it embarrassing enemas. And you can be sure nurse will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combi tion of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Ke in mind, however, that the drug is contraindicate the acute surgical abdomen.

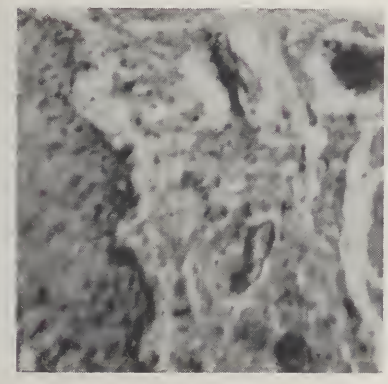
Dulcolax®...it's predictable

bisacodyl



Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502



JOHN E. ADAMS, MD, EDITOR

pathology

Innovations in Blood Procurement

Procurement of blood of high quality in amounts sufficient to meet the needs of all patients at all times with a minimum of out-dating is a constant major problem for the average hospital blood bank. Through the years the American Red Cross and more recently the Maryland Blood Exchange, under sponsorship of the American Association of Blood Banks, have provided a major portion of the blood used by the community. Peaks and valleys are frequent, however, since it is difficult to coordinate patient need and procurement by these methods. Also, these operations depend upon motivation of the public to donate. Consequently, major effort by individual blood banks still is necessary to insure a supply that is appropriate to the demand and to combat the persistent problem of out-dating.

Three innovations in blood procurement have been instituted at the Greater Baltimore Medical Center since the opening of the hospital in 1965. These programs, combined with standard hospital blood procurement practices, have produced significant improvement in patient care and in Blood Bank efficiency and economy.

Employee Blood Assurance Program

This program, modeled after the American Red Cross Blood Assurance Programs but with important differences, is offered to all permanent hospital employees. The employee (or a satisfactory donor substitute if the employee is not eligible as a blood donor) agrees to donate blood when called upon but not more than twice a year. In return, the hospital guarantees the full replacement of all blood used by the member employee and most members of his family and household, including in-laws. At the time of entry into the program, the member or his donor substitute is preprocessed with regard to history, hematocrit, serology, atypical antibodies and blood group and type, and in some cases antibody titering. This data, as well as his work hours, date of last donation, hours of availability and pertinent phone numbers are kept on file and the donor is called for a specific blood need according to a patient's blood requirement. Type-specific blood thus can be obtained fresh and to order. Since donors are drawn according to current need, out-dating of blood is decreased. Credits obtained through these donations are transferable to any other hospital in the country through the American Association of Blood Banks and the American Red Cross.

More recently this program has been opened to non-employees who are recruited at the time of a replacement donation for a patient. In three months, 85 non-employee families have been processed into the program; these members, if anything, are more enthusiastic about the program than are the employees.

Obstetrical Blood Assurance Program

The expectant mother, through her obstetrician, is asked to provide one donor prior to termination of her current pregnancy. The program is not mandatory; however, success is achieved by the fact that in return the hospital assures the full replacement of all blood used during that pregnancy.

Predeposit For Elective Surgery

By means of letters to the attending surgeon, patients scheduled for elective surgery on whom blood coverage is requested are asked to provide donors prior to admission to the hospital, equal to the number of units of blood requested by the surgeon. Again, the program is not mandatory but has been successful by working through the attending physician and by being better able to assure blood coverage at the time of surgery. Predeposit by the patient himself is also encouraged; a unit of blood may be drawn about 18 days prior to surgery and held for that patient only.

Through these programs, the blood bank can provide freshly drawn blood of a specific or unusual type more readily and upon request. Dependence upon commercial and other outside blood sources is greatly reduced. Quality control of blood is enhanced since the blood is under "house" control from donor to patient. In each program blood donation is strictly voluntary but because of the inducements offered and the interest stimulated, the result is effective blood procurement.

The large back-up provided by the preprocessed walking donor list is of inestimable value in procuring type-specific blood in emergency situations. Far less effort and time are expended on donor procurement and procurement of bank blood from outside sources. Easing of the burden of blood procurement produces a more satisfactory work environment in the Blood Bank and provides for better relations with the medical staff when their blood needs can be met with regularity. The Obstetrical Blood Assurance Program and the Predeposit Program, although not type-specific drawing programs, provide an important back-up for the routine replacement methods which so often lag, particularly on weekends or holidays.

The patient and the hospital have been the clear beneficiaries of these programs. Because of a lack of need, the paid professional donor is unknown in this hospital. Dependence upon outside blood sources such as commercial blood banks and the Red Cross has decreased markedly. The least expensive blood is blood drawn and processed at the place where it is to be used. Blood procurement costs to the hospital and thus to the patient are reduced and the patient receives better quality care. During the 38-month period from September 1965 to November 1968 this blood bank obtained 154 pints of blood (all drawn for type-specific need) from the Employee Blood Assurance Program and replaced a total of 16 pints to three members of that program. The Obstetrical Blood Assurance Program yielded 520 pints of blood in the same time period, while blood usage by these patients totaled 22 pints. Encouragement of predeposit yielded 384 pints of blood in 22 months from donors provided by patients about to undergo elective surgery; these same patients used 86 pints of blood during their surgery. Therefore, the total blood *credit* or excess from these three programs was 934 pints in three years. During the same period, with the help of these programs the blood bank of this hospital was able to reduce its blood deficit to the Red Cross from 755 pints to about 100 pints.

We believe that these programs, especially the Blood Assurance Program, can be utilized effectively by most other hospitals. With the hospital as the base, such programs could be extended in the community to involve virtually all families not covered by Red Cross or other programs. Administrative detail with a type-specific assurance program is increased considerably and modern data processing support is mandatory for such a comprehensive program. However, with such support there would seem to be no deterrent to the development of a program encompassing virtually all uncovered population in the metropolis, providing a massive walking donor file, preprocessed and listed as to qualifications and availability, for use at any hour for any need by every hospital in the area.

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Highlights

State Health Department Submits Request for 1970 Budget

The Maryland State Department of Health has submitted a budget request of more than $167 million for fiscal year 1970. Almost $100 million of the total request is earmarked for the State's Medical Assistance Program.

It includes 372 positions necessary for the Department to keep abreast of the increasing demands for health-related services. A general breakdown of the 1970 budget request and comparison with 1969 appropriations follows:

	1970 Request	*1969 Appropriations*
Medical Assistance	$ 99,872,712	$ 50,164,821
Local Health Services	30,950,261	26,408,524
Headquarters	7,097,751	4,730,951
Chronic Hospitals	8,861,515	7,353,308
TB Hospitals	3,719,474	3,345,068
Preventive Medical Services	9,039,553	7,079,047
Crippled Children's Services	5,292,203	3,065,850
Environmental	2,832,260	1,763,700
TOTAL Department Request	$167,665,729	$103,911,269

The budget request is almost austere, and in view of the State's serious economic dilemma, it is sure to suffer some cuts during the 1969 legislative session scheduled to begin within the next few weeks. It has become apparent that this year's legislative session will be of more conservative temperament than that witnessed during the last few sessions. Maryland legislators are faced with what is bound to be, to them, the distasteful task of either increasing taxes or severely slashing State spending in an attempt to balance the budget.

Cancer Project Directors Meet

Project directors of cervical cancer screening programs now under way in seven Baltimore area hospitals met November 21 in the State Office Building, 301 W. Preston Street, to report progress and plan future case-finding activities.

The meeting was jointly sponsored by the Maryland State Department of Health and the Cancer Control Program of the National Center for Chronic Disease Control, U. S. Public Health Service, grants from which provide funds to conduct the hospital-based program of cervical cancer detection. Attending the meeting were approximately 40 people.

The Health Department's Division of Cancer Control, under Edward A. Sawada, MD, was instrumental in obtaining the Federal grants for the participating hospitals, which include: Baltimore City, Bon Secours, Provident, Sinai, Union Memorial, University of Maryland, and Spring Grove State Hospitals.

Purpose of the case-finding projects is to establish a uniform program to screen all women hospitalized or treated in hospital outpatient departments for cervical cancer.

U. S. Public Health Service physicians from Arlington, Va., New York City, and Philadelphia reported on their experience in case-finding in these areas. Other speakers included physicians and professional personnel from U. S. Public Health Service, the Maryland State Department of Health, and project hospitals, with additional resource participants from the Baltimore City and County Health Departments, and the Maryland Division of American Cancer Society.

Central Laboratory Location Shifted

The 1969 General Assembly must consider as one of its first acts a change in the law in order to permit the Health Department's proposed six floor laboratory to be built in the new Preston Street Complex. Construction was scheduled to begin on the labs at Guilford Avenue and 20th Street early in the summer of 1969.

The Preston Complex plans call for further expansion of the present State property that will meet the needs of office space through the year 2000. Included in the plans is a modernistic complex of low buildings that will do for the 300 block of West Preston what the Charles Center is doing for downtown. The plan calls for underground parking, elevated pedestrian walkways, and clusters of buildings allowing the State as much as six million square feet of office space when completed. The plans for the new complex were revealed to State officials on November 15.

During the past year, new branch laboratories in the recently completed Cecil County and the Talbot County Health Centers were occupied. Minor modifications with slight enlargement were completed in the Cheverly Branch and the Annapolis Branch Laboratories. Currently, a complete relocation of the Rockville Branch Laboratory is being planned, and final work drawings are nearly completed for new laboratories at Salisbury and at Cambridge, in new Health Centers. Plans for laboratories in a large Health Center at Cumberland are also in progress.

Progress in Water Supply and Wastewater Planning

In 1966, legislation was enacted which requires that each county submit a comprehensive water supply and wastewater plan by January 1, 1970. In October, the Division of Water and Sewerage received from Worcester County the first preliminary draft of such a plan. Several other counties have completed two-thirds or more of the planning effort; however, others are lagging, and the mean progress made throughout the State is approximately 36%. Efforts are being made to accelerate planning activity in those counties that have not yet made substantial progress.

Emergency Health Readiness in Maryland

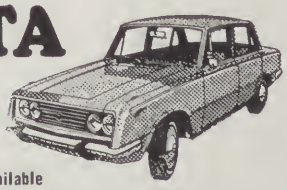
The State of Maryland ranked among the top nine states in health readiness to meet major emergencies, according to the Division of Health Mobilization's (USPHS) 1968 Annual Report. The report compared all states in eight specific readiness categories: Medical Self-Help Training, Emergency Health Service Training, Hospital Preparedness, Packaged Disaster Hospital Program, Packaged Disaster Hospital Training Program, Hospital Reserve Disaster Inventory Program, City Emergency Health Service Readiness, and State Emergency Health Service Readiness.

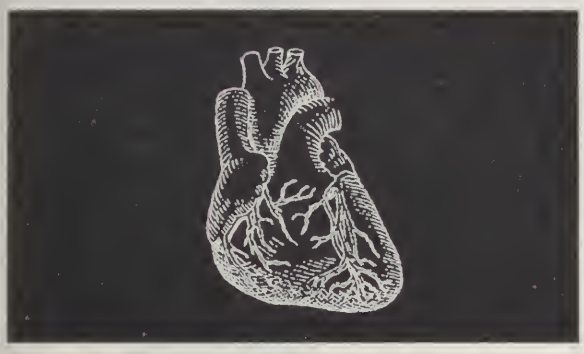
The Division of Emergency Health Services is primarily responsible for the eight program areas evaluated in the report.

U. S. Department of HEW Designates D.C. Area as Air Quality Control Region

On October 1, the Secretary of Health, Education, and Welfare formally designated the Washington Metropolitan Area as an air quality control region under terms of the Federal Clean Air Act. The area encompasses Montgomery and Prince George's Counties in Maryland, the District of Columbia, and Fairfax, Arlington, Prince William, and Loudoun Counties in Virginia, and includes the independent cities in those Virginia counties.

TOURS ARRANGED TO MEDICAL CONFERENCES AND CONCLAVES
Domestic and International
GLOBETROTTER TRAVEL
A Professional Travel Service
BALTIMORE: REISTERSTOWN ROAD PLAZA • 358-6444
BALTIMORE: MONDAWMIN SHOPPING CENTER • 669-8200
WASHINGTON: WHEATON PL. SHOPPING CTR. • 949-1700

BE AHEAD! See and Drive the new '69
TOYOTA
From $1666 P.O.E.
CROWNS—CORONAS
COROLLAS
Standard & Automatic
Factory Air-Conditioned available

FULKER MOTORS
4925 Belair Rd. 488-6400
Over 35 Years Same Location



JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Cardiac Amyloidosis

Amyloid is a fibrillar glycoprotein deposited in the tissues of man and animals under a wide variety of clinical and experimental conditions. Pathologically, it is homogeneous, eosinophilic and demonstrates a characteristic green birefringence when stained with congo red and viewed under polarized light.

Clinically, amyloid occurs as (1) a primary systemic disease frequently associated with a dysproteinemia, (2) secondary to chronic diseases such as rheumatoid arthritis or tuberculosis, (3) in familial forms, or (4) as localized deposits in single organs.

WERNER F. BARTH, MD
Assistant Professor and Head
Division of Arthritis
University of Maryland Hospital

Cardiac involvement by amyloid may be the predominant clinical manifestation in cases of familial amyloid, may occur in the absence of amyloid elsewhere as in senile cardiac amyloid and is the most common site of involvement and cause of death in the primary systemic form.

Amyloid is deposited extracellularly and interferes with function by encroaching upon and replacing normal tissue. In the heart, amyloid is found in all three layers, the heart valves and in the coronary arteries. Heart weight is often increased but size may appear normal due to loss of elasticity and distensibility.

Congestive heart failure is the most common clinical expression of cardiac amyloid, occurring in approximately half the patients. Failure may be predominantly left-sided, right-sided, or both. Amyloid is a cause of the "Stiff Heart" syndrome and may mimic constrictive pericarditis. In fact, pressure tracings at cardiac catheterization in both familial and primary forms have been similar to those obtained in constrictive pericarditis of other causes. Angina pectoris due to amyloid involvement of the coronary arteries has been described but is infrequent. Involvement of the conduction system may lead to various degrees of heart block and syncope. Orthostatic hypotension is a disabling symptom and reflects autonomic nervous system involvement.

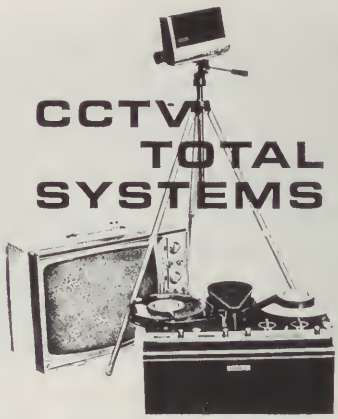
The electrocardiogram is usually abnormal with low voltage, axis deviation and conduction defects all described. The EKG may show Q waves suggesting myocardial infarction but at autopsy this is frequently due to myocardial replacement by amyloid rather than true infarction.

Cardiac amyloid may be an incidental autopsy finding in the elderly, clinically silent, and noncontributary as a cause of death. In a recent series, localized cardiac amyloid was found at autopsy in 10% of people over age 80 and in 50% of those over 90. In those patients with clinical evidence of heart failure, prognosis is

poor once symptoms have appeared. Symptoms are progressive and frequently intractable to the usual modes of therapy, with death occurring in six months to two years following onset of symptoms.

On the basis of our own experience and that of others, caution is advised in the use of digitalis and diuretics in these patients. Digitalis sensitivity on standard doses of the drug, resulting in arrhythmias and even sudden death, has been described by numerous investigators. Maintenance of adequate venous pressure and venous return is important in a "Stiff heart syndrome" such as amyloidosis. Overzealous diuresis may severely reduce cardiac output, leading to renal or cerebral insufficiency.

Amyloidosis should be suspected as a cause of unexplained heart failure in any elderly patient. Index of suspicion should be even higher in those patients with macroglossia, carpal tunnel syndrome or purpura. Hepatic and/or renal failure may also be present. Definitive diagnosis can be obtained by biopsy and congo red stain. Recommended biopsy sites include rectal mucosa, gums, muscle and bone marrow.



CCTV TOTAL SYSTEMS

PLANNING, ENGINEERING, INSTALLATION & SERVICE

We Feature **AMPEX**

VIDEOTAPE RECORDING EQUIPMENT

Call Today for a Free Demonstration

high fidelity house

6307 YORK ROAD (Drumcastle) BALTIMORE, MD.

Phone 323-3713

when treatment requires

MOIST HEAT

for the relief of pain



Suggest the Battle Creek

THERMOPHORE

Arthritis? Rheumatism? Aches from Flu, Colds, Sore Muscles? Enjoy oh-so-soothing **relief!** Apply pain-relieving **moist heat** with a wonderful Battle Creek **Thermophore.**

Easy to use. Just "snap the switch." Gives relaxing pain-soothing moist heat in seconds! Use no water. No Messy "wet packs." You've never felt help like this!

Phone for Free Descriptive Literature, or See It At . . .

THERAPEUTIC APPLIANCES, INC.

JULES MORSTEIN

1114 Light St. **Phone 752-6996**

Baltimore Md. 21230

WOMEN OF ALL AGES

Train for a rewarding career as

MEDICAL ASSISTANT

- Short, comprehensive course in day or evening classes prepares you fully for this challenging and well-paid profession. Modern, air-conditioned classrooms with the finest equipment. Highly competent faculty. Free placement service for our graduates.

Approved by Maryland State Dept. of Education

PROGRESSIVE · ETHICAL · PROFESSIONAL · MARYLAND ACADEMY OF DENTAL ASSISTANTS

DOCTORS....

OUR INTERNSHIP PROGRAM

offers you the services of a trained assistant for post graduate internship without salary obligation.

Call or write for full details.

MARYLAND ACADEMY OF MEDICAL & DENTAL ASSISTANTS

Executive Two Bldg. 32 West Road

Towson, Maryland 21204

Phone: 821-5222



A Service of the Tuberculosis Association of Maryland

tuberculosis

Smoking, Sputum, and Lung Cancer

J. Rimington, M.B., Ch.B. *British Medical Journal,* March 23, 1968.

Chronic bronchitis, as evidenced by chronic cough and daily sputum production over a period of years, was the most significant symptom among men diagnosed as having lung cancer following a mass chest X-ray screening. The relationship between chronic sputum production and lung cancer among tobacco smokers was clear. No cancer was found among nonsmokers.

In connection with a mass miniature radiography screening, the relationship between lung cancer, persistent daily sputum production, and tobacco smoking among men 40 years of age or older was investigated. The men were volunteers from the general public and industry.

The subjects were asked whether they smoked or had smoked and, if so, how much they smoked. They were also asked questions about raising phlegm. If sputum had been produced daily for five years, it was considered a symptom of chronic bronchitis. If abnormalities were observed on X-ray film, the individual was referred for further investigation, and six months later a follow-up was carried out. The chest physician who read the original film had no information on the smoking habits and sputum history of the subject.

Lung Cancer Proved

Only volunteers who had lesions confirmed as lung cancer by surgery, biopsy, post-mortem examination, or follow-up were admitted to the study.

Among the 21,579 men in the study, 33 cases of lung cancer were diagnosed. No case was found among nonsmokers. The highest number was among cigarette smokers.

The smoking categories and number of cases of cancer in each were:

Category	*(Subjects)*	*Cases*
Nonsmokers	(2,826)	0
Cigarette smokers	(11,934)	23
Ex-smokers	(4,516)	5
Pipe smokers	(2,267)	5

The rates for lung cancer among the cigarette smokers rose from 1.35 per 1,000 persons for light smokers to 2.47 per 1,000 for heavy smokers. The rate for the group as a whole was 1.93 per 1,000. The rate for ex-smokers was 1.10 per 1,000. The majority of former smokers, including the five who had cancer, had smoked cigarettes.

Risk Declines for Ex-Smokers

These data support findings of other studies that people who had stopped smoking had a lower risk of cancer than current smokers but a greater risk than nonsmokers. Four of the five former smokers who developed cancer had given up smoking only the year before the X-ray examination, which was not the case with the majority of the ex-smokers. It is possible that some of the ex-smokers had developed cancer while still smoking cigarettes.

The rate of cancer among the pipe smokers was

high, 2.21 per 1,000. It may be that previous cigarette smokers were among the current pipe smokers.

In 25 of the 33 lung cancer cases, histologic examinations were made. In 14 persons, the cancer was squamous cell; in five, undifferentiated; and in four, oat cell. Two were adenocarcinomas.

Increased chronic bronchitis mortality with increasing amounts of tobacco smoked has been reported. Several studies indicate that chronic bronchitis and productive cough are both related quantitatively to smoking habits, and the frequency of persistent cough with phlegm has been found to be as high as 42% in heavy cigarette smokers aged 55 to 64 years. In the present series, with its five-year minimum of sputum production, the percentages were lower, as was the average age.

Rates Related to Sputum

The rates of cancer per 1,000 subjects in relation to sputum were as follows: smokers without sputum, 1.30; smokers with sputum, 5.09; ex-smokers without sputum, 0.24; ex-smokers with sputum, 10.13; pipe smokers without sputum, 0.97; pipe smokers with sputum, 13.76.

Lung cancer rates for the subjects with persistent daily sputum are considerably higher than those without sputum in each smoking category. This relationship is also maintained among those with histologically proved cancer, 0.63 for those without sputum and 4.78 for those with sputum. The rates are significant in all categories. (Two cancers among cigarette smokers without sputum were adenocarcinomas, which do not appear to be associated with smoking.)

Since both productive cough and lung cancer are associated with cigarette smoking, it is possible that the high rate of lung cancer among the cigarette smokers with persistent daily sputum for five or more years is due to the association of both conditions with cigarette smoking. In view of this possibility the cigarette smokers have been divided into three consumption categories—light, medium, and heavy—but, irrespective of the amount smoked, the lung cancer rates for those with persistent daily sputum are considerably higher than for those without this symptom.

While a very slow-growing lung cancer could cause chronic cough, it is difficult to believe such a cancer could result in excessive sputum production over a long period of time. None of the volunteers with lung cancer who said they had chronic sputum production had such a respiratory disease as tuberculosis or bronchiectasis to account for the sputum. The reasonable assumption is that the sputum was due to chronic bronchitis.

Smoking Plus Cough

In other studies it has been found that the lung cancer mortality of smokers with a morning cough three years prior to death was three to five times greater than that of those without cough.

It seems clearly indicated that anti-smoking propaganda should be directed at the high-risk bronchitic group, and smokers with a chronic cough or sputum should understand that they are at considerable risk of lung cancer. They should be urged to stop smoking and to seek radiologic supervision.

Many might be sufficiently convinced of the seriousness of their situation to give up smoking. As for the others, early radiologic detection of lung cancer can only serve to improve the chances of a surgical cure, slight though that might be.



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg., Dextromethorphan hydrobromide, 7.5 mg.
A. H. Robins Company, Richmond, Virginia 23220
A·H·ROBINS



(New TUBEX® are constantly being added)



Only TUBEX® offers so complete a line of closed system injectables

and it's still growing.

To meet your present needs more precisely, the Tubex line comprises 37 different products in 69 dosage variations. And more are on the way.

Tubex offers these unit dose advantages:

- **accuracy**—premeasured, clearly labeled to help ensure correct medication
- **convenience**—no filling, no needle-sharpening, no sterilization, no cleanup
- **simplicity**—precision-made, well balanced syringe breech loads in seconds, permits easy aspiration
- **reduces risk**—single-use cartridge-needle units reduce risk of cross contamination; less chance of spillage reduces risk of contact sensitization for doctor or nurse
- **stability**—glass cartridges can't deteriorate or react with medication
- **acceptability**—presharpened, siliconized needles lessen pain of injection; patients appreciate single-use equipment

Just select, inject, throw away

TUBEX®

Wyeth®

UD UNIT DOSE MEDICATION

sterile cartridge-needle unit

Wyeth Laboratories Philadelphia, Pa.

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City
health department

Malnutrition in Baltimore's Children

The following report on the problem of malnutrition among Baltimore's children will be of interest to physicians. The analysis and proposals were prepared by Matthew Tayback, ScD, Deputy Commissioner of Health for Baltimore City, with the assistance of members of the Department's nutrition and child health services staff as presented in the Commissioner's *Weekly Letter to the Mayor* dated October 10.

Evidence of Malnutrition

There is unequivocal evidence that malnutrition exists among significant numbers of our children.

1. Among infants seen in well-baby clinics, that is, infants from low-income families and who are 6 months to 2 years of age 75% have hemoglobin values below 11 gms per cent. Among children of similar age and who are from middle-income and upper-income families, less than 10% would have hemoglobin values below 11 gms per cent. Low hemoglobin values indicate iron deficiency anemia. This condition occurs at a rate six-fold higher in low-income infants than among children of more favored economic circumstances.

2. Among preschool age children, 2-5 years of age, who are seen in pediatric centers caring for children from low-income circumstances, the rate of retarded physical development is in the range of 12-15%, four-fold greater than that found in the general population of children. The retarded physical development is believed due to poor nutrition of low-income children, existence of which is confirmed by nutritional surveys undertaken by nutritionists in our Child Hygiene Services section.

3. Among women, who are from poor economic conditions, and who bear children, the rate of birth of premature babies is 16%, which is twice the rate found in mothers from more favored circumstances. It is now believed that this difference is due, principally, to the accumulated effects of poor nutrition among young women who come from low-income families.

Proposals for Correction of Malnutrition

The problem of malnutrition among infants affects not less than 5,000 infants from families in poor economic circumstances. A major impact upon the problem can be made by providing such infants a milk formula fortified with iron and with vitamins. The milk formula should be given for the first six months of the life of a newborn child. A longer period is desirable, but significant changes can be achieved by the six-month program.

Among the 5,000 infants who require fortified milk formula support, 3,000 are located in the Model Cities Area. To support an infant with free milk formula for six months will cost $50 per infant or for 3,000 infants the cost would be $150,000. It is my expectation that this urgent matter will be considered by the Coordinating Council of the Model Cities Agency and I sincerely hope that they may recommend inclusion of this service in the Model Cities program for fiscal 1969. Two thousand infants requiring free milk formula distribution are located outside of the Model Cities Area. A sum of $100,000 needs to be allocated to provide the appropriate prepared milk formula. At the present time, I know

of no other source of funds to achieve this distribution than the general fund of the City.

The problem of malnutrition among children of preschool age is difficult to attack. By and large it derives out of limited economic resources of families on public assistance and in income levels below the poverty level. However, there is a good resource available to assist poor families in obtaining more adequate food. This resource is the Food Stamp program, federally funded, supervised by the U.S. Department of Agriculture, and locally managed by the Baltimore City Department of Social Services. This program is not functioning well in this City.

At a conference which I convened on this program at which representatives of the U.S. Department of Agriculture, the City Department of Social Services, Legal Aid East, and the City Health Department were present, the following observations and recommendations were made:

Participation in this program has not been satisfactory by low-income families, either those on public assistance or non-public assistance. While 90% of all public assistance clients are eligible, only 24% are using the food stamps to purchase their family food supplies. As of September, 1968, there were 760 non-public assistance families using the stamps. It is estimated that the number of such families in need would equal not less than 5,000.

Because of the exceptionally limited participation in the food stamp program, and the demonstrated need, simple changes in procedure need to be made. These are:

1. "Authority to Purchase" cards, now issued monthly, should be issued once each six months.
2. Minimum cash contribution by the family in order to benefit from food stamps should be reduced.
3. Eligible families should be permitted to purchase food stamps on a weekly or biweekly basis.
4. Distribution points for food stamp acquisition should be more accessible both geographically and time-wise.
5. Income eligibility levels for non-public assistance cases should be raised.

We believe that a large number of elementary school children are not receiving adequate lunch regularly. In most communities, the school lunch program is the means by which one is assured that each child will receive an adequate meal at lunch. In Baltimore, we have a school lunch program and other related feeding programs which are not reaching all of the children that are in need. This is due to the fact that (1) cost of lunch, $ .35 per day, is beyond the means of children from low-income families, the number of such children in elementary schools being approximately 30,000, and (2) no school lunch program is available in many inner city schools.

Although it is true that free meals are available, the number of such meals daily is less than 3,000 while the need is close to 30,000. For example, in the City of Washington, with an elementary school population less than Baltimore's, the number of free lunches is 10,000 daily.

In our early study of the matter of feeding school age children we have identified the following federally funded programs which are available.

1. National School Lunch Act
2. Special Milk Program—U.S. Department of Agriculture
3. Breakfast—U.S. Department of Agriculture
4. Child Nutrition Act of 1966
5. Elementary-Secondary Education Act—Title I
6. Surplus Commodities for Group Care of Children

To the best of my knowledge no single agency has assumed responsibility to secure for Baltimore the fullest benefits from these programs. There is a necessity, therefore, for the designation of an agency to work with the appropriate federal and state offices so that Baltimore may better receive an appropriate share of funds allocated for the nutrition of children. For example, in the City of Washington, each child receives daily a half pint of milk without charge (and largely federally funded). No such program of free distribution exists in Baltimore. This may be possible by better utilization of the provision of the Child Nutrition Act of 1966.

The City Health Department is prepared to undertake further work towards strengthening the program for nutrition of low-income Baltimore residents, and to encourage the implementation of the recommendations cited above. In view of the fact that negotiations with federal and state agencies may be necessary, the designation of an appropriate agency to accomplish this should be made by your office.



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

A Guide: To Help You Find Your Way Around

Periodically, it seems appropriate to inform our readers about the latest reference aids in various subject fields, or biographical and organizational directories. Following are some of the latest biographical listings received by this library.

Biographical Reference Titles

General

International Medical Directory.
Published by World Medical Association, United States Committee, Inc. A limited list by country.
n.d. [1968] **R 10.5 W6**

World Who's Who in Science Chicago, Marquis Who's Who.
A biographical Dictionary of notable scientists from antiquity to the present.
1968 **Q 141 W6**

Canadian Medical Directory, 14th. Toronto, Seccombe House.
Physicians listed alphabetically and geographically. Includes a variety of general topics, including medical associations, schools and journals, hospitals, care plans. . . .
1968 **R 713.01 C3**

The Medical Directory. London, J & A Churchill, Ltd.
Members of the profession in Great Britain listed alphabetically in 2 volumes. The second volume also lists medical schools, colleges and hospitals.
1968 **R 713.29 M4**

American Public Health Association Directory.
Lists members and fellows—alphabetically and geographically. Also names the Governing Council, Affiliated Associations and Regional Branches, Agency Members and Sustaining Members.
1967 **RA 421 A5 1967**

American Men of Science. N.Y., R.R. Bowker Co.
6 volumes containing biographies of scientists in Physical and Biological sciences. 7th and 8th volumes cover the Social and Behavioral Sciences. Entries selected on the basis of 1) Achievement, 2) Quality of research activity, 3) Position of responsibility.
1968 **Q141 A5**

State and Local

Other local rosters are available as published in the respective journals. This list includes only those received recently.

The Johns Hopkins Directory.
Faculty and administrative personnel. Also partial listing of Homewood Campus Officers, and complete department directory for medical institutions, services and clinics.
1968-1969 **R 712.A2 J6**

Louisiana State Board of Medical Examiners.
Physicians, surgeons, podiatrists, midwives and physical therapists who were legally qualified by the state for 1968.
1968 **R 712.A2 L7**

Medical and Chirurgical Faculty of the State of Maryland.
Membership directory by county, with index. Also lists affiliate members; gives specialty, hospital affiliations, and society memberships. Hospitals are listed by county.
1968-1969 **RM A2 M4**

Medical Association of the State of Alabama.
Roster of the Association. List by counties, gives colleges attended and address. Alphabetical list gives telephone number.
1968 **R 15 .A5 M4**

The Suffolk County Medical Society and The Suffolk Academy of Medicine Bulletin.
Tenth annual directory. Hauppauge, N. Y. Members listed alphabetically, geographically and by specialty. Also lists hospitals and community agencies in the county.
1968

University of Maryland Student-Faculty Centre telephone directory.
Information includes address and specialty. Student section also adds year of professional training. Baltimore Campus only.
1968-1969

Specialties

American Association of *Hospital Consultants.*
Directory 1968-69. Information concerning each. Consists of address, present connection, type of service, associates, biography, professional societies.
1968-69 **RA 971 A5**

American Association of *Ophthalmology.*
Membership directory. Alphabetical and geographical listings.
1967 **RE 22 A5**

American College of *Allergists.*
Membership Directory, published biennially. Alphabetical and geographical listings.
1967 **RC 585 A1**

American College of *Surgeons.* 1968 Directory.
Lists medical and dental schools as well as fellows of the College alphabetically and geographically. Also contains pertinent information concerning the administration and history.
1968 **RD 10 A5**

American *Pediatric* Directory. 13th ed. Knoxville, Joe T. Smith.
A roster of pediatricians of the U. S. and Canada with complete professional biography. Geographical.
1967-1968 **R 712 .A1 A5**

American Society of *Anesthesiologists.*
1968 Directory of members. Listed alphabetically and geographically. Includes By-Laws of the Society and various related topics.
1968 **RD 83.A2 A5**

American *Urological* Association, Inc.
Alphabetical and geographical roster of membership. Revised to November 1967. **RC 870 A5**

Biographical Directory of the American *Psychiatric* Association. New York, R.R. Bowker Co.
Alphabetical and geographical listings. Lists related and affiliated societies and associations.
1968 **RC 335 A5**

Directory of *Medical Specialists.* Chicago, Marquis Who's Who.
Physicians in 19 medical specialties certified by the American Specialty boards. Listed alphabetically, first by the specialty, then geographically by state and city. Alphabetical index. Information listed *as of 1967.*
1968-1969 (13th ed.) **R 712.A1 D5**


MERCEDES-BENZ

Baltimore's only Authorized Dealer for Sales, Service and Parts

R. & H. Motors, Inc.

4810 Belair Rd. **426-9200**

Baltimore, Md. 21206

SKILL SURGICAL, INC.



SUPPLIES & EQUIPMENT
for
PHYSICIANS–SURGEONS
HOSPITALS

5406 Harford Road **Phone 254-2800**

BALTIMORE, MD. 21214

New Accessions: Books

(arranged by author and title)

Adler, Bill, comp.
Prescription: laughter; an athology of medical merriment. New York, Harcourt, Brace & World [1968].

American Opthalmological Society.
Transactions of the annual meeting. 1967. Toronto

Archivio dei Centri Traumatologici Ortopedici dell 'Istituto Nazionale Infortuni. Milano. 1966.

Avery, Mary Ellen
The lung and its disorders in the newborn infant. 2d. ed. Philadelphia, Saunders, 1968.

Bauer, William Waldo
Today's health guide. Chicago, American Medical Association, 1968.

Bender, Arnold E.
Dietetic foods. New York, Chemical Publishing, 1968.

Berkowitz, Monroe
The processing of workmen's compensation cases. Washington, U.S. Govt. Printing Off., 1967.

Blakemore, William S.
Current perspectives in gastroenterology. New York, Harper and Row, Hoeber Medical Division, 1967.

Boorman, Kathleen E.
An introduction to blood group serology. 3d. edition. Boston, Little, Brown, 1966.

Cailliet, René
Foot and ankle pain. Philadelphia, F. A. Davis Co. 1968.

Criep, Leo Hermann.
Dermatologic allergy: immunology, diagnosis, management. Philadelphia, Saunders, 1967.

Decennial Review Conference on Cell Tissue and Organ Culture, 2d., Bedford, Pa., 1966.
Proceedings. Bethesda, Md. U.S. National Cancer Institute, 1967.

Gaylin, Willard, comp.
The meaning of despair; psychoanalytic contributions to the understanding of depression. New York, Science House, 1968.

Gofman, John W.
A specific common chromosomal pathway for the origin of human malignancy. Livermore, California. University of California, Lawrence Radiation Laboratory, 1967.

Goligher, J. C.
Surgery of the anus, rectum and colon. 2d. ed. London, Baillière, Tindall & Cassell, 1967.

Goth, Andres
Medical pharmacology; principles and concepts. 4th ed. St. Louis, C. V. Mosby Co., 1968.

Hampers, Constantine L.
Long-term hemodialysis: the management of the patient with chronic renal failure. New York, Grune and Stratton, 1967.

International Cancer Congress, 9th, Tokyo, 1966.
Proceedings. Berlin, New York, etc. Springer-Verlag, 1967.

Irregular serials & annuals; an international directory. 1st ed. New York, Bowker, 1967.

Iversen, Torben
Leukaemia in infancy and childhood; a material of 570 Danish cases. Copenhagen, Munksgaard, 1966.

Lampe, Kenneth F.
Plant toxicity and dermatitis; a manual for physicians. Baltimore, Williams & Wilkins, 1968.

Louisiana State Board of Health.
Statistical report of the division of public health statistics. New Orleans, Louisiana State Board of Health, 1967.

Louisiana State Board of Medical Examiners.
Official list: physicians, surgeons, podiatrists, midwives, physical therapists. New Orleans, Louisiana State Board of Medical Examiners, 1968.

Maryland State Planning Commission. Committee on Medical Care.
Community health service analyses. Baltimore, Maryland State Planning Commission, 1962.

Medical Library Association.
Directory. 1968.

Morley, Muriel E.
Cleft palate and speech. 6th ed. Baltimore, Williams & Wilkins, 1966.

Morley, Muriel E.
The development and disorders of speech in childhood. 2d. ed. Baltimore, Williams & Wilkins, 1965.

Moskowitz, Eugene.
Rehabilitation in extremity fractures. Springfield, Ill. Thomas, 1968.

The Prevention of highway injury; proceedings. Ann Arbor, Highway Safety Research Institute, University of Michigan, 1967.

Sanazaro, Paul J.
Health services research in Great Britain. Washington, U. S. Public Health Service, 1968.

Sarner, Harvey
Insurance for the doctor. Philadelphia, W. B. Saunders Co., 1967.

Serum groups. Editors: Kaj Gert Jensen & Sven-Aage Killmann. Baltimore, Williams & Wilkins, 1968.

U. S. Communicable Disease Center, Atlanta, Ga.
Training program bulletin. 1968-9.

U. S. Congress. Senate. Committee on the Judiciary. Subcommittee on Antitrust and Monopoly.
The Medical restraint of trade act. Hearings, Ninetieth Congress. Washington, U. S. Govt. Print. Off., 1967.

U. S. National Center for Air Pollution Control.
The Federal air pollution program. Rev. Washington. U. S. Govt. Print. Off., 1967.

U.S. National Institutes of Health. Division of Research Grants.
Research grants index. 1967. Washington, U. S. Govt. Print. Off.

Waksman, Selman Abraham
Scientific contributions of Selman A. Waksman; selected articles published in honor of his 80th birthday, July 22, 1968. New Brunswick, N. J., Rutgers University Press, 1968.

The Year book of cancer. Chicago, Year Book Publishers. 1967-8.

SKIN PROBLEMS

Caused by itching due to:

Dry Eczema	Acne
Chafing	Ivy Poisoning
Minor Burns	Cold Sores
Athlete's Foot	Heat Rash
Dry Skin	Diaper Rash
Wind Burn	Chapping
Insect Stings	Hemorrhoids

For Safe, Sure, Speedy Relief —
— Get RESINOL GREASELESS!

Medical Scientists have conquered 6 dread diseases in the past decade, but they are largely in the dark, they admit, in finding relief for one age-old ailment—itching



New remedies containing antibiotics have been tested, but have often caused side effects which are worse than itching skin. After many years of research and testing, Resinol Greaseless Cream was developed. . . . A doctor's formula containing safe yet powerful ingredients, Resinol Greaseless contains an amazing, proven "anti-itch" medication called Resorcin, which quickly and effectively relieves most any kind of itching. Try Resinol Greaseless . . . You'll be delighted to find that it really works! At all drug stores. Buy a tube today.

Family First Aid in a Tube
Carry in Purse or Pocket
A Medicine Cabinet "Must"

"Resinol Really Works"

RESINOL CHEMICAL COMPANY
517 W. Lombard St.
Baltimore, Md. 21201

4 Million Diabetics Here—

Some 1.6 million persons in the United States—a majority of them women—have diabetes and do not know it, the Health Insurance Institute said recently.

Add this to the 2.4 million known diabetics in the U. S. for a total of 4 million—again, the majority of them women—with a disease for which there is no known cure, but which can to some extent be controlled.

It also appears that on the average, women have more severe cases of diabetes than men.

She's Old, Heavy

An analysis of U. S. Public Health Service studies of the "sugar disease" indicates that the type of person most likely to be diabetic is an elderly woman with a weight problem.

These three points stand out:

- Nearly six out of ten known diabetics in the United States are women.
- The prevalence of diabetes increases with age, with a peak in the 65-to-74 age group. Researchers have found that in most cases diabetes is not diagnosed until a person is 45 years or older, perhaps because the disease does not strike until then.
- There is a definite relationship between diabetes and obesity. A recent screening of Federal employees indicated that diabetes occurs seven times more frequently among overweight people compared to those of normal weight.

Stress Weight Control

Most doctors agree that avoidance of obesity is the most important, frequently the only measure, that will help reduce the incidence and severity of diabetes in older people.

The National Health Survey found that women, on the average, were disabled by diabetes for substantially longer periods than men.

1.6 Million Don't Know It

Women had an average of 58 days of restricted activity annually, contrasted with 48 days for men. Women averaged 27 days a year in bed because of diabetes while male diabetics averaged 18 days. This higher level of female disability occurred at all ages except 75 years and over.

The most frequently reported symptoms of diabetes are extreme fatigue, leg pain and eye trouble.

Other symptoms include sudden weakness, frequent urination, thirst, loss of weight, and abnormal appetite, national figures on diabetics show.

In each of these instances, women consistently report more of these symptoms than men. They also report a larger variety of symptoms as they grow older.

Among the most serious characteristics of diabetes is that it often is linked to other chronic conditions.

According to the National Health Survey, four out of five diabetics in the United States have at least one chronic illness in addition to diabetes, while 58% have three or more illnesses.

Can Go Blind

The conditions reported most often were heart problems, hypertension, and impaired vision and blindness.

In a study of 17 chronic illnesses most often found in diabetics, women were usually more affected by these conditions often by a ratio of at least two to one.

Amputated fingers or toes, the absence of major extremities, and tuberculosis were characteristics most often found among male diabetics.

Probably the most sobering fact about the disease is that most medical men agree that despite advances in care, the primary goal of prevention or cure of diabetes is far from being met.

We lease car,

not cars (plural). Car (singular). When a professional man like you wants just one car.

We do one-car-at-a-time leasing with plans particularly appropriate for the professional man. Plans designed to give you the same advantages as enjoyed by big companies that lease.

These advantages include: the new '69 you want as you want it, no capital tied down in a depreciating asset, no separate maintenance or insurance bills, convenient service without extra charge at thousands of "Happy Motoring"® stations throughout the United States, exact transportation costs records on a single monthly bill for tax accounting, no trade-in problems or losses.

Many physicians and surgeons are now leasing. With good reason. Ask your nurse or secretary to drop us a note, or call us, for a detailed booklet explaining the Humble Leasing Plan.

HUMBLE LEASING COMPANY
457 Central Avenue
Newark, New Jersey 07107
Telephone: (301) 837-4510



DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

DRINK MORE MILK
for your health sake



- More Vitamins
- More Minerals
- More Energy



Deliveries in Maryland, Washington, and Virginia.

Life Begins With Embassy Milk

EMBASSY DAIRY
DU 7-1441

1620 First St. N.W.
Washington, D. C.

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

FREE GIFT For taking a test drive. Come in and inspect our beautiful new facilities.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL

5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

RUG CLEANING

Of the Highest Quality at Reasonable Prices

ORIENTAL & DOMESTIC

- Repairing
- Installing
- Storing
- Moth-proofing

Expert Oriental Rug Repairing & Reweaving

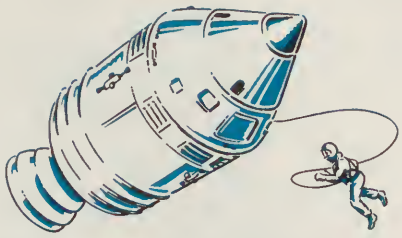
SPECIALISTS IN
CLEANING WALL-TO-WALL CARPETS
AND FURNITURE IN YOUR HOME

A large selection of Antique and Modern Oriental Rugs and Carpets Available

EST. 1922

Hanna
IMPORTER

HOpkins 7-6600
2015 W. 41st ST.
Baltimore, Md.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



When the pink pill for U.R.I. symptoms speeds into action, someone somewhere breathes easier.

u provide prompt and continuous ef from symptoms of U.R.I. when prescribe Novahistine Singlet. vahistine Singlet is formulated to ckly relieve the fever and the aches pains that so frequently accompany er respiratory infections. And these tinuous-release tablets provide a oconstrictor-antihistamine formu- on to shrink swollen membranes reduce congestion of the tur- ates and sinuses.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW



Geigy



Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.

One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Regroton produces a smooth, long-acting effect that usually reduces both systolic and diastolic pressures. At the same time it often acts to allay anxiety and nervous tension associated with hypertension.

Although Regroton is generally well tolerated, adverse reactions may occur. This drug is contraindicated in mental depression, demonstrated hypersensitivity, and most cases of severe renal or hepatic diseases. For a complete list of side effects, please see the Prescribing Information summarized on the following page.

Regroton®

chlorthalidone 50 mg.
reserpine 0.25 mg.



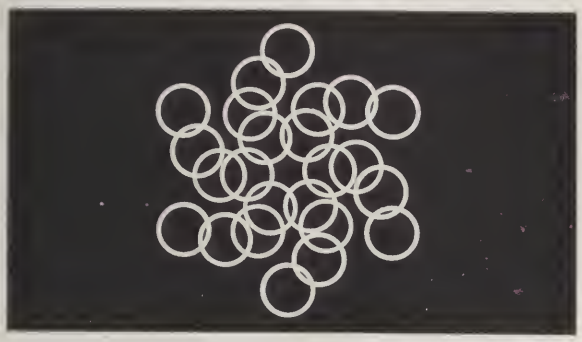
One Regroton tablet a day usually helps you and your patient bring high blood pressure down and keep it down.

Indications: Hypertension. **Contraindications:** History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. **Warning:** With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers. **Precautions:** Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. **Adverse Reactions:** The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. **Average Dosage:** One tablet daily with breakfast. **Availability:** Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C

For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6225



From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

A Physician Considers His Responsibility for Treating Alcoholics

Alcoholism has officially been considered an illness by the AMA for more than ten years, but only recently is it being accepted to any appreciable degree by individual physicians, and by society, as an illness.

RICHARD H. ANDERSON, MD *

I firmly believe alcoholism is an illness, an illness for which the alcoholic cannot be held responsible or be condemned. It is a chronic disease, with characteristic relapses even after treatment has commenced. Too often, we shame the alcoholic or show our disgust for him because of his breaking a promise to remain sober, but he is *addicted* to alcohol!

Professionals from many fields have been neglecting the alcoholic: nurses, social workers, ministers, vocational rehabilitation counselors, probation officers, judges, police and, of course, physicians. All of these people come in contact with the alcoholic when he is down, when he is most vulnerable to treatment and rehabilitation. All of them, and society in general, which is probably partially responsible for the illness, have an obligation to assist the five million alcoholics in this country, but few are meeting this responsibility.

Physicians have the biggest responsibility. We are often in a position to diagnose the illness before anyone else, simply by taking an adequate history and examining the patient. We see the patient when he has the shakes and can't sleep, when he has alcoholic gastritis, when he wrecks his car, when he is hit over the head with a beer bottle, and when the police drop him drunk at our hospitals.

We have the responsibility to diagnose the illness, to treat the acute stages, to confront the alcoholic with the diagnosis, and to refer him to the proper treatment program. We have not met this responsibility. Because conventional psychotherapy proved ineffective, and because alcoholics often seem unmotivated, most psychiatrists abandoned them; because alcoholics do not follow instructions and are not dependable, and because their symptoms are frustrating, most general physicians abandoned them. Because of their own ambivalent feelings about drinking and inability to understand that will power alone won't work with alcoholics, their families and society in general abandoned them.

* Dr. Anderson is a member of the Faculty's Subcommittee on Alcoholism. The above paper is revised from an address he delivered before the Harford County Medical Society, October 16, 1968.

A recovered alcoholic is writing a series of articles on alcoholism for a Baltimore County weekly newspaper. One of his articles concerns the medical profession.

". . . Many law enforcement officers, judges, lawyers, ministers, social and welfare workers have repeated opportunities to help as they encounter alcoholics during crisis situations and more times than not they fail. And what about doctors and nurses?

"The medical profession is in an excellent position to wave the red flag in the face of the developing alcoholic. But too frequently this does not occur. I have heard many recovering alcoholics tell of their first encounter with the family physician over the amount of booze consumed. Usually the advice they received was, 'Cut it down to one or two a night'; or, 'Just drink beer'; or 'Stop'. The 'Stop' may also be accompanied by a prescription for a tranquilizer. And the alcoholic addict bounds off with a ticket for another hang-up in addition to his alcoholism. . . .

"I suppose, to be perfectly fair, that we can't lay all the blame at the feet of the doctors and nurses. After all, until just the last few years, medical schools have offered little meaningful education regarding this illness. A doctor friend of mine has told me that if a doctor is over 35, he has probably received no more than one or two hours of education on alcoholism, the illness that ranks fourth on the list of public health problems. I once heard another doctor say that his one hour lecture on alcoholism consisted of detailed instructions on how to get a drunk out of the waiting room without disturbing the rest of the patients!

"Is this all that we can expect from our medical schools and the products that they turn out? Fortunately some few doctors and nurses have educated themselves about alcoholism and they work very effectively with alcoholic patients. But shouldn't all of the graduates from our medical and nursing schools be equipped to identify and treat the alcoholic?

"This will not happen overnight. And my frustration will continue at least for a while, especially when I think of the millions of alcoholics who have prematurely died over the last 20 years or so. Their death certificates do not show alcoholism; more likely they show cirrhosis, heart disease, stroke, T.B., or auto accident, but seldom alcoholism.

"Is it any wonder that the anger boils up inside when I ask someone to help an alcoholic and I get a shrug of a shoulder or a reply, 'Why?' I hear 10,000,000 reasons whisper back, 'Why not?' "

The Comprehensive Intoxication and Alcoholism Control Act was recently passed by the State Legislature. For the first time, that I'm aware of, a group of lay people told us, the medical profession, how to treat a particular disease. They don't tell us how to treat diabetes, heart disease, or cancer! They told us that alcoholism is a disease, and that we must have detoxification units in our hospitals for the detoxification or drying out of drunks. An insult! *But* we have not met our responsibilities as physicians.

This law does not allow the alcoholic to continue to be treated as a criminal, and it does not allow physicians and hospitals in Maryland to continue turning their backs on alcoholics. Now as winter is coming, our hospitals and emergency rooms are going to be overflowing with drunks. It is unfortunate that hospital administrators were not included in the planning of this bill, and it is unfortunate that the appropriations bill which accompanied it was not passed, but we have to do the best we can. I don't know how hospitals are going to cope with the expected increase in volume, but they must make more effort: It is the law.

Treating the alcoholic for alcohol withdrawal is not difficult 95% of the time. It does not usually require a private room, a private nurse, a locked door, restraints, or prolonged hospitalization. It does often require a thorough work-up for medical complications of alcoholism, adequate sedation with one of a number of tranquilizers, vitamins and an adequate diet, and then referral to the local alcoholism clinic and/or AA group, and perhaps referral to a state hospital for longer hospitalization and rehabilitation. Delirium tremens, which is relatively uncommon and which is a true medical emergency with a 5-30% mortality rate even with treatment, often does require restraints, private nurses and extensive medical care. But D.T.'s can be prevented by treating the alcoholic in the early withdrawal phase instead of letting him dry out at home.

If physicians will accept alcoholism as an illness and not a moral problem, and will accept intoxication as an exacerbation of the illness, there cannot be resistance to the general hospital treatment of alcoholics. If physicians realize that alcoholism is the fourth major health problem in the country, that there are five million alcohol

addicts and 20 million problem drinkers in the country, how can hospital treatment be denied? If physicians will realize that they can initiate a recovery that does indeed occur, and if physicians realize that alcoholics can be useful citizens, how can they deny them treatment?

Let's ask ourselves where the intoxicated alcoholic should be taken for treatment? Jail? He is not a criminal. The State hospitals? They are understaffed and staffed mainly by psychiatrists who should not be treating the medical problem of the acute withdrawal syndrome. His home? It is often a single room, a flophouse, or the street, where he will only drink again, or die with D.T.'s. Or the hospital? Is there really any choice among these alternatives?

Let us begin treating the alcoholic as a sick person with all the dignity, compassion, patience and understanding physicians are expected to have.

FELLOWSHIP AND RESEARCH GRANTS

in the fields of

TUBERCULOSIS AND CHRONIC RESPIRATORY DISEASES

From: Maryland Tuberculosis Association
Maryland Thoracic Society

Deadline for Application: February 15, 1969

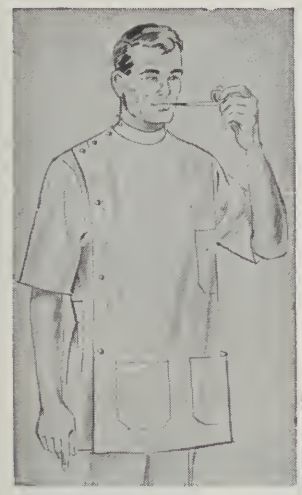
For information and application forms please write:

C. Canby Robinson Memorial Fund Committee
Maryland Tuberculosis Association
11 East Mount Royal Avenue
Baltimore, Maryland 21202
Att: Executive Director

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

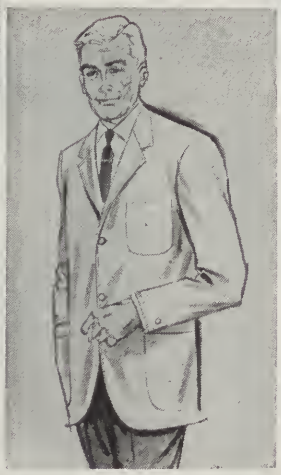
#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

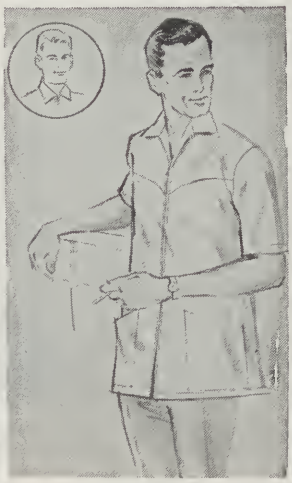
#800—100% Nylon Taffeta **$5.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only
Sizes 34 to 46



Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200



MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab. **$9.99**

Sizes 28-40

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46

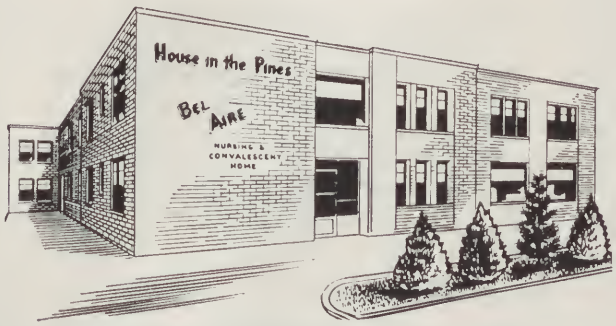


Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639

OTHER STORES IN →

When Professional Experience Counts

The House In The Pines Staff Is Able and Ready To Serve!



BEL AIRE . . . 5837 Belair Road • CL 4-8800

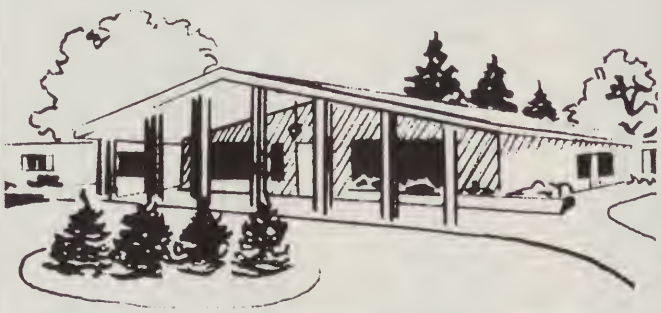


BELVEDERE . . . 2525 W. Belvedere Ave. • FO 7-9100

Conveniently located 1 block from Sinai Hospitol.



CATONSVILLE . . . 16 Fusting Avenue • RI 7-1800



EASTON, Md. . . . Rt. 50 & Dutchman's Lane • TA 2-4000

HOUSE IN THE PINES Nursing and Convalescent Homes offer efficient, round the clock care under the direct supervision of registered nurses, 24 hours a day.

The aged, convalescent and the chronically ill guests enjoy a modern, home-like atmosphere with the most up-to-date medical and therapy equipment at their side.

Complete physical and occupational therapy programs are available. The recreational programs are designed to full-fill the needs and desires of our guests.

Excellent food is served, and special diets catered to, under the direct supervision of our licensed staff dietician.

Physicians orders are followed explicity!

HOUSE IN THE PINES
NURSING HOMES

Your Inspection Invited
Brochure Upon Request



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

Medical Personnel Shortages Polled

America's doctors say their communities are having moderate-to-severe nurses shortages.

The opinions were compiled in a monthly opinion poll conducted nationally among physicians by Marion Laboratories, Inc.

The Playback poll was answered by 1,156 doctors.

Fifty-nine percent of these physicians agree there is a nurses shortage. This is in close agreement with a poll of the general public announced in May by George Gallup. Cardiologists answering the Playback Poll apparently feel the nurses shortage the worst, "other specialists" the least.

Geographically, the nurses are in too-low supply everywhere, but especially in Arizona, Georgia, Illinois, Louisiana, Mississippi, New Jersey, Oklahoma, Texas, Utah, and West Virginia.

The doctors feel there are doctor shortages, too, in some communities, especially in Arkansas, Iowa, Maine, Montana, North Carolina, and Nevada.

BALTIMORE OXYGEN SUPPLY CO., INC.

OHIO CHEMICAL DISTRIBUTORS

Therapy and Medical Gases
Oxygen Tents
Resuscitators and Apparatus

PHONES: 789-8100 727-4748

Main Office and Plant

LINTHICUM, MARYLAND 21090

YOUR HEADQUARTERS FOR

PHOTOGRAPHIC EQUIPMENT

. . . for Medical, Surgical, and Research Applications

Phone LE 9-5763

PHOTOCENTER

23 N. Howard St. Baltimore, Md. 21201

Al-Lin Ambulance Service

"AT THE BELTWAY"

4811 E. LEEDS AVE. BALTIMORE, MD. 21227

24 Hour Emergency Ambulance and Oxygen Service

Trained and Experienced Personnel

2 Way Radio Controlled

247-2111

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

Do Your Patients Need Nursing Service?

Call 889-5666

COBB-WOODS SERVICES

Vera Woods, M. A. Director.

2213 St. Paul St. Baltimore, Md. 21218

Licensed by the State of Md.

MANUEL SCHWARTZ

HEARING REHABILITATION

802 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201

DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION

Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

Expansion at the University of Maryland

The next campus building to be completed will be the Shock Trauma Center, which will probably be occupied late this year. The center was planned around a 12-bed patient area on the top floor, with labs quickly accessible on the third floor directly below. The second floor is reserved for operating rooms and a cardiac catheterization lab and the first floor for offices.

A high pressure chamber on the ground floor will be used to treat shock by literally drenching needy tissues with oxygen.

Under the direction of R. Adams Cowley, MD, a full-time staff of doctors, nurses, and technicians will gradually be assembled to man the center 24 hours a day. With the cooperation of the City and State, a helistop is being planned for the future, to speed arrival of patients in shock, particularly those severely injured in highway accidents.

State Medical Examiner's Building

On the corner of Pratt and Penn streets, the state medical examiner's building is nearing completion and will be occupied in 1969.

A basement and three floors will provide 30,000 square feet, of which 7,000 square feet on the top floor will be devoted to research and teaching under the direction of Russell Fisher, MD, who besides being chief medical examiner is professor and head of the medical school's division of forensic pathology.

School of Dentistry

During the fall of 1969 the six-story dental school building should be completed. It will permit expansion of the entering class from 100 to 128 students, and will provide space for training dental hygienists and dental assistants.

The curriculum changes that were planned in conjunction with the new building will put the school in the forefront of dental education, according to Dean John J. Salley.

School of Nursing

Construction of a new building for the School of Nursing at the corner of Penn and West Lombard streets began in July.

Dean Marion I. Murphy reports that the new six-floor building will provide 59,710 square feet of space to accommodate growing classes. Completion is expected by the summer of 1969.

North Hospital

Bids for the new North Hospital Building, which will almost double present hospital space, were opened October 24. When this building is completed in 1970, along with the contemplated 13-story addition to Howard Hall and continued modernization of the present hospital, this campus will be far better equipped to fulfill its essential new role in health education and service to the citizens of Maryland.

A & F Nurses Registry



LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

Registered & Licensed

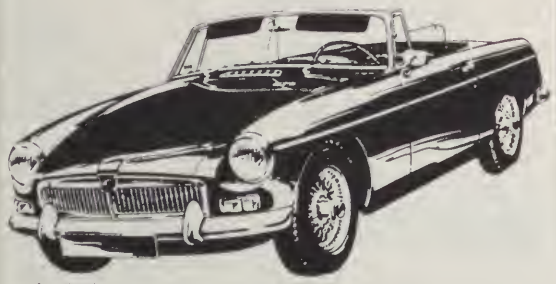
For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.
BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

Prescription for Pleasure!

MGB



Sleek lines, magnificent performance, the latest in classic line—the MGB. Cruise comfortably in this automobile at speeds up to one hundred and ten miles an hour with the assurance of steady rack and pinion steering and fade-proof front disc brakes. The performance-bred heritage of the MG Octagon is legend; the MGB must be driven to be appreciated.

BRITISH IMPORTS, LTD.
1028 YORK RD. SOUTH OF BELTWAY EXIT 26
DIRECT FACTORY IMPORTERS
PHONE 828-0010
Open Monday through Saturday 9 to 9
Service Department Open 9 to 6; Wed. 9 to 9

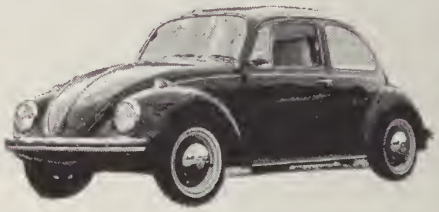
- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE
EVANGELICAL
PRESS

THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"

VOLKSWAGEN



Hobelmann Motors, Inc.
AUTHORIZED DEALER

Bank Financing
814 Light St.—Baltimore, Md. 21230
727-4400
Open 9 to 9

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION
ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE
DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily
Tuesday Evenings 7 to 9

355-9300
PATAPSCO AVENUE & FOURTH STREET
Baltimore, Maryland, 21225

HOOD CONVALESCENT HOME
"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF
CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED
National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM
Certificate Holder—Baltimore County
Fire Prevention Bureau Award
LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800
5313 EDMONDSON AVE.



ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

Minutes

Eight of the members of the Board of Directors of the Baltimore City Medical Society met on November 12, 1968. The meeting was called to order by D. Frank Kaltreider, MD. The minutes of the October 8th meeting were read and approved. The first item on the agenda was a correspondence from Gustav G. Voigt, MD, informing Dr. Kaltreider that the regional advisory group of the Regional Medical Program approved the cardiac ambulance proposal. Dr. Voigt informed the Board that the proposal now goes to Washington and if approved there, funds may be available to launch the program in July 1969. Dr. Voigt expressed his gratitude to the Executive Council of the Baltimore City Medical Society for their support and agreed that regular meetings between the Project Director and the Baltimore City Medical Society should be arranged and felt this step was important in establishing communication and rapport between the interested groups.

The next item on the agenda were committee reports submitted to Dr. Kaltreider from the various committees of the Baltimore City Medical Society. These reports were read and were to be distributed at the Society's Annual Meeting in December. They are also on file in the office of the Society for those who are interested. Of special interest was the committee report submitted by Philip F. Wagley, MD, Chairman of the Policy and Planning Committee. This important committee submitted a list of five recommendations to the Board of Directors. The First recommendation was that the Society continue to participate in discussions of the Health Sciences Consortium so that the Society can keep abreast of development in health education and possibly formulate contributing roles. Secondly, letters were sent to 17 State Medical Societies in connection with considering the role of an executive director. Fifteen answers were received. After much discussion by the Policy and Planning Committee, it was recommended that no executive director or secretary be appointed at this time. It was the consensus of this committee that no lay person, and no one individual physician can substitute for increasing involvement in participation of a part of the membership of this Society. Thirdly, and along the same line of thought, the Committee recommended that candidates for membership in this Society be required, before admission, to attend at least two orientation meetings where they would be informed as to the role of this Society in the community life. Also, it is recommended that the Society assess the particular interest of the candidate so that their services may be more fully utilized. The Committee thinks the admission of candidates at this time is so casual and rather routine so that the new member is not stimulated to play a truly participating and contributing role in the functions of the Society. Fourthly, it has been the consensus of the Committee that the socio-economic problems remain important ones for the Society. Along that line, at the last meeting of the Committee, the suggestion was made that funds be set aside for use in the following general manner; to defray a significant amount of the cost of the pre-medical and medical education of some young student in the inner city. Consideration might be given, for example, to a trainee in paramedical studies in the Dunbar High School. Many details and lines of guidance will have to be formulated explicitly for this. However, the present Committee suggests that this is a topic of study for the next Policy and Planning

Committee. Fifthly, and obviously, the current Policy and Planning Committee recommends most strongly that the work of the Committee be carried on through the appointment by the next President of a similar group.

A letter was read from the President of the Woman's Auxiliary of the Baltimore City Medical Society, Mrs. Karl F. Mech, informing the Board of Directors that the Woman's Auxiliary is in need of financial and clerical help. After some discussion by the Board of Directors, it was decided that Mrs. Mech should be invited to the next meeting of the Board of Directors and more explicitly outline her problems and needs.

Under new business, the Society was solicited by "The Orthopedic Research Foundation" for funds. It was decided by the Board that, although the Board encourages the function of this foundation, and is sympathetic towards their cause, funds were not available for contribution from the Society.

Marvin Schuster, MD, presented an outline protocol to the Board of Directors pertaining to the training of ileostomy and colostomy patients. This protocol was to be submitted to the Regional Medical Program Committee for their support. Dr. Schuster requested that the Board of Directors lend support to such a program. After some discussion, the program was approved by the Board of Directors and they agreed to support its institution.

The next item under new business was a discussion and the appointment of a committee to negotiate and arbitrate for purposes of unification of the two existing City Medical Societies.

The meeting was adjourned at 5:30 PM.

ARTHUR E. COCCO, MD
Journal Representative

Montgomery County Medical Society

Merton L. White, MD, a Silver Spring physician for the past 20 years, has been elected the 65th president of the Montgomery County Medical Society.

A native of Buffalo, New York, Dr. White graduated from Georgetown Medical School in Washington, D. C. He served in the United States Navy during World War II and still holds a position in the Navy Reserves.

Dr. White brings much experience to the office of president, having served the Society as treasurer and vice president, as chairman of the Professional Relations Committee and as a member of the Legislative, Constitution and Bylaws Committee.

At the Society's Annual Dinner Dance held at the Woodmont Country Club, the responsibility of the presidency and the gavel were transferred to Dr. White by Marvin I. Mones, MD, retiring president. Dr. White, in turn, presented Dr. Mones with the Past President's Plaque.

Howard County Medical Society

At the last bi-annual meeting of the Howard County Medical Society, the following officers were elected for two-year terms beginning this month:

President is Peter Van B. Thorpe, MD; George Burgtorf, MD, is vice president; Art Panayis, MD, secretary; Theodore Shrop, MD, treasurer; Thomas Herbert, MD, was chosen as delegate to the Medical and Chirurgical Faculty, and Justinas Kudirki, MD, was elected alternate delegate.

Visit the #1 Spot for Your Diet Needs
Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)
For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic
SPECIAL DIET SHOP
Phone SA 7-0383

COLOSTOMY
ILEOSTOMY
Appliances and Disposable Bags
CALL
FIELDS PHARMACY
IN PIKESVILLE
for convalescent supplies and service
FOR RAPID DELIVERY 486-3300



The MEDICAL and CHIRURGICAL FACULTY
of the State of Maryland

ACCIDENT AND HEALTH PROGRAM FOR FACULTY MEMBERS

- **ACCIDENT AND SICKNESS TOTAL DISABILITY**
- **MAJOR MEDICAL EXPENSE**
- **ACCIDENTAL DEATH AND DISMEMBERMENT**

Administered by
THE MED-CHI INSURANCE TRUST

Official Faculty Agent
B. Dixon Evander and Associates

Underwritten by
Hartford Accident and Indemnity Company

Member of
The Hartford Insurance Group
Hartford, Connecticut

For more information detach and mail slip directly to:

MED-CHI INSURANCE TRUST
1211 Cathedral Street, Baltimore, Maryland 21201

*Name*_____

*Address*_____

*City and State*_____ *Zip Code*_____

PROFESSIONAL

PHYSICIAN WANTED—To work in evaluation clinic at University of Maryland Hospital 3-5 mornings a week. Prefer physician under 55 years of age. Contact: William L. Stewart, MD, 955-8242.

INTERNIST—Needed for full time appointment at the Veterans Administration Hospital, Baltimore. For full information phone 467-9932, ext. 110. The Veterans Administration is an Equal Employment Opportunity Employer.

ADMINISTRATOR—For new convalescent and nursing center now in operation. Experience in Medicare procedures and prior experience in nursing home administration preferred. Excellent opportunity. Send resume to Box #2, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

PHYSICIANS WANTED—Two general surgeons and one internist for two-year overseas assignment. Board certified, over 35, salary and related benefits. One surgeon required for service in Caribbean area available immediately; surgeon and internist for Afghanistan July, 1969. Interested parties contact MEDICO, a Service of CARE, 660 First Ave., New York, N.Y. 10016. Phone: (212) 686-3110.

POSITION WANTED

UNIVERSITY-TRAINED CARDIOLOGIST-INTERNIST—Desires part time position evenings or weekends in Baltimore area. Phone: (301) 666-0027 eves.

FOR RENT

UNUSUAL OPPORTUNITY—For group of physicians and medical lab. Northern Arundel Co., heavily populated, on transit route, close to Sea Girt Inn. New building. All city conveniences—ample parking, ambulance service, 20 minutes to major hospitals—South Baltimore General and North Arundel. Space for 10 medical suites and pharmacy. Most liberal rental incentive. Contact: Frank F. Levay, SA 7-0955, 255-8552.

HOME-OFFICE COMBINATION—Ideal for physician. Spacious rambler on busy St. Barnabas Rd., Oxon Hill, Md. Central a/c, baseboard heat, fenced wooded acre, parking area, double garage, paneled gameroom, two fireplaces. Nr. Cafritz Hosp., churches, schools & Beltway. Redecorated. Available immediately. Phone: (301) 894-2800.

Advertisers in This Issue

Abbey Rents 16
A & F Nurses Registry 109
Al-Lin Ambulance Service 108
Arundel Federal Savings & Loan Assoc. 110
Baltimore Federal Savings & Loan Assoc. 7
Baltimore Nurses Exchange, Alice Weber 6
Baltimore Oxygen Supply Co., Inc. 108
Brentwood Inn 16
British Imports, Ltd. 109
Broadview Restaurant 47
Burroughs Wellcome & Co., Inc. 75
Campbell Soup Co. 39
Capital Savings & Loan Assoc. 108
Oscar Caplan & Sons 8
Central Dodge, Inc. 43
Clifford's Family Care Service 28
Club Venus 47
Cobb-Woods Services 108
Cork 'n Bottle Restaurant 47
Dobbs House 47
Doctors Supply Co. 96
Dulaney Towson Nurs. & Conv. Home 35
Eagle Printing Co. 34
Eastern Research Laboratories, Inc. .....3rd Cover
Eleven East Chase St. Corp. 16
Embassy Dairy 96
Equitable Trust Bank 48
Evangelical Press 110
Fedder's Medical Services 8
Federated Business Services, Inc. 30
Fields Pharmacy 112
Forty West Volkswagen 28
Franklin Uniform Co. 105
Fulker Motors 82
Geigy Pharmaceuticals 78, 100-102
Glenbrook Laboratories 15
Globetrotter Travel Agency 82
Hanna Rug Co. 96
Hecht Co. Northwood Rooftop Restaurant 47
Hidden Brook 28
High Fidelity House 84
Highland Hospital 18
Hobelmann Motors, Inc. 110
Hood Convalescent Home 110
House in the Pines Nursing Homes 106
Humble Leasing Co. 95
Hynson, Westcott & Dunning, Inc. 1
International Pharmaceuticals Corp. 66-67
Jobst Service Center 29
Lederle Laboratories 3, 19-20
Eli Lilly & Co. 4
Maico Hearing Aids, Inc. 49
Maria's 300 Restaurant 47
Maryland Academy of Medical & Dental Assistants 84
Mercantile-Safe Deposit & Trust Co. 32
Michaelson Motors, Inc. 18
Miller Bros. Restaurant 47
Milton Inn 47
Monarch Lincoln Mercury, Inc. 96
Murray-Baumgartner Surg. Instr. Co., Inc. 11
Obetrol Pharmaceuticals 23
Olney Inn 49
Palmer House 47
Parke, Davis & Co. 21
Photocenter 108
Pitman-Moore 98-99
T. Rowe Price Growth Stock Fund, Inc. 34
Professional Management Co. 11
Wm. P. Poythress & Co., Inc. 97
Geo. Radebaugh & Sons 31
Read's Drug Stores 16
R & H Motors, Inc. 92
Resinol Chemical Co. 94
A. H. Robins Co. 12-13, 42, 86
Roche Laboratories .....76-77, 4th Cover
Rose Exterminator Co. 18
Manuel Schwartz, Hearing Rehab. 108
G. D. Searle & Co. 40-41
Skill Surgical, Inc. 92
Special Diet Shop 112
Sterling Lighting Co. 17
Mano Swartz, Furs 8
Therapeutic Appliances, Inc. 84
Tijuana Tacos 47
D. Stuart Webb Advertising Services, Inc. 17
Westview Lounge & Supper Club 47
White Rice Inn 47
Winthrop Laboratories 22
Wyeth Laboratories 44-45, 87-88, 107
Zimmerman's Shoes 8

Index to Vol. 17,

Maryland State Medical Journal

January-December, 1968

SUBJECT INDEX

Adolescent

CHAPMAN, P: Hippie talk: from acid to zap (Oct) 66-7

FARBER, RE: Reducing teen-age pregnancy (Oct) 91

PINCOCK, CS: Our turbulent youth (Oct) 58-64

RANDALL, L: Unwed teen-age mother (Feb) 145-6

Advertising

LECHNER, CB, DH COYNE: Journal advertising—yes or no? (Nov) 41-42

Alcoholism

ACTON, C: Detoxification of the alcoholic patient (Sept) 123-6

BEACHAM, EG: 1st year review of alcoholism program, TB division, Baltimore City Hospitals (Aug) 108-110

DE HOFF, JB: Prevention and treatment of alcoholism: Impracticable—low priority program? (May) 81-3

OKEN, F: Maryland's Alcoholism Control Law and the general hospital (Dec) 71-4

Position statement on implementation of comprehensive intoxification and Alcoholism Control Act (Nov) 91-3

PRESNALL, LF: Folklore and facts about employees with alcoholism—part II (Jan) 95-9

SHENKMAN, M: The family physician and alcoholism (July) 87-8

Training sessions on treatment of alcoholics (Oct) 111

TUERK, I: Attitudes and alcoholics (Apr) 110-11

One man's view of alcoholism and the alcoholic (June) 119-120

WEISMAN, MN: Use of disulfiram in the treatment of alcoholism (Mar) 83-4

Arteritis

RICHARDS, RD: Temporal arteritis: a cause of blindness (July) 64-7

Arthritis

COHEN, BS: Osteoarthritis (Apr) 152-5

Asthma

LONDON, RL: Diagnosis and management of bronchial asthma (Aug) 82-9

Baldness

WEIGAND, DA: Alopecias—diagnostic and pathogenetic considerations (Mar) 61-9

Birth Control

BALL, P: Some apparently common problems in patients receiving contraceptive pills (Apr) 91-5

FARBER, RE: Family planning clinics (Aug) 121

Preventing teen pregnancies (May) 87-8

Blindness (see Arteritis)

Blood

BAYLESS, TM: Gastrointestinal Hemorrhage (Sept) 72-4

GOTT, VL: Current status of priming solutions for pump oxygenators (Sept) 68-9

JACKSON, DP: Hemorrhagic disease (Sept) 70-1

Indications for platelet transfusions (Sept) 78-9

LEVIN, J: Diagnosis and treatment of the hemophilias (Sept) 75-7

MORSE, EE: Survey of blood use in Baltimore (Sept) 57-8

PERT, JH: Laboratory and clinical results with improved methods of preparing fresh and frozen platelet concentrates (Sept) 84-5

RUTHERFORD, RB: Current concepts in the use of whole blood in the management of hemorrhagic shock (Sept) 65-7

SERPICK, AA, WR MILLER: Use of platelet transfusion in the treatment of leukemia (Sept) 80-83

VALERI, CR: Clinical effectiveness of concentrated liquid stored red cells and previously frozen red cells (Sept) 59-64

Cancer

BERGHUIS, JW: Metastasis and development of malignancy in benign colonic polyps (Jan) 60-2

Multiple roads of cancer research (Feb) 38-9

SERPICK, AA, WR MILLER: Use of platelet transfusion in the treatment of leukemia (Sept) 80-83

Chronic Disease (see also Geriatrics)

CARROLL, DG: A specialty in search of identity (May) 73-6

Collagenoses

SCHOOLMAN, LR: A gamut of "collagenoses" (Mar) 70-1

Diabetes

GASTINEAU, CF: Care of unstable diabetes (July) 68-70

Drugs
Drugs of abuse (Oct) 50-3
FARNSWORTH, DL: Drug problem among young people (Oct) 81-5
EDDY, NB, et al: Drug dependence: its significance and characteristics (Oct) 57
Marihuana and society (Oct) 54-6
SCHAEFER, JF: Chloromycetin (chloramphenical): a "fall guy"! (Oct) 49
Generic prescribing (July) 62-3
WURMSER, L: Drug addiction and drug abuse—a synopsis (Oct) 68-80

Ear
HILL, CL: Cryosurgery and its application to ear, nose, and throat surgery (Jan) 54-7

Executive Secretary (newsletter)
SARGEANT, J:
(Jan) 17-18
(Feb) 17-18
(Mar) 17-18
(Apr) 17-18
(May) 9-10
(June) 9-10
(July) 9-10
(Aug) 9-10
(Sept) 9-10
(Oct) 9-10
(Nov) 9-10
(Dec) 9-10

Faculty, Medical and Chirurgical of the State of Maryland
Business sessions: Minutes (June) 147-56; (Nov) 60-72
Reports to house of delegates 1968: (June) 39-100; (Nov) 48-59
SARGEANT, J: Your medical faculty at work
(Jan) 71
(Feb) 110-11
(Apr) 101
(May) 77-8
(June) 101-04
(July) 81-2
(Aug) 106
(Oct) 87-8
(Nov) 36
(Dec) 75-6

Gastrointestinal
BAYLESS, TM: Gastrointestinal hemorrhage (Sept) 72-4

General Practice
COHEN, AR: Certification and the GP (Aug) 107
Maryland Academy of General Practice (Aug) 16

Geriatrics
AMA's committee on aging: it strives to prolong life—and living (Aug) 139-40
BENACK, RT: Role of extended care facilities, nursing homes and personal care homes in the care of the chronically ill (July) 77-80
TUERK, I, K GORWITZ: Retention and release rates of geriatric admissions (Feb) 147

Health Services
FARBER, RE: (Baltimore City Health Department)
(Jan) 74
(Feb) 128-9, Public health in Baltimore in 1967
(Mar) 77
(Apr) 112
(July) 89, Infant immunization report
(Nov) 105-6
(Dec) 84, Psychiatric day center
PEEPLES, WJ: (State of Maryland Department of Health)
(Jan) 76-7
(Feb) 115-6
(Mar) 81-2
(Apr) 125
(May) 89, Recommendations concerning PKU diagnosis, treatment, and follow up
(June) 130-1
(July) 101-2
(Aug) 117-8
(Sept) 101-2
(Oct) 99-101
(Dec) 79-80

Heart
CARROLL, DG: Cardiac rehabilitation—follow up after myocardial infarction (Jan) 78-9
DEMBO, DH: Nurse's role in cardiopulmonary resuscitation (Sept) 89-90
HUMPHRIES, JO: New methods for the prevention and treatment of ventricular arrhythmias (Mar) 75-6
LEE, YC: Vectorcardiography, (Aug) 111-2
LEWIS, KB: Cardiac rehabilitation—a coronary care unit (Feb) 130-2
MC LAUGHLIN, JS: Heart transplantation (July) 91-2
MARKOWITZ, MM, L GORDIS, R RODRIGUEZ: Problems in preventing initial attacks of rheumatic fever (Jan) 72-3
NEILL, CA: Progress in pediatric cardiology (June) 117-18
PRICE, TR: Neurological manifestations of heart disease (Nov) 103-4
Recommendations to physicians relative to reducing the risks of coronary heart disease (May) 85
Risk factors and coronary disease (Apr) 106-7
SCHERLIS, L: Death: the diagnostic dilemma (Dec) 77-8
WISWELL, JG: Hyperthyroid heart disease (Oct) 97-8

Indians
SPARGER, CF: Straight pin ingestion in an American Indian boarding school (Nov) 43-7

Iron
CONRAD, ME: Factors affecting the body iron content (Apr) 76-90

Kidneys
LUBASH, GD: Renin-angiotension system and hypertension (Feb) 112-14

Laboratory
AMA establishes approval program for certified laboratory assistants (Apr) 139
Laboratory services (Feb) 83-6

Library, Medical and Chirurgical Faculty
(Jan) 25
(Feb) 31-3, 151-2
(Mar) 78-9
(Apr) 22-3, 114-5
(May) 93
(June) 14-15, 139-42
(July) 12-13, 103-5
(Aug) 26-7, 131-3
(Sept) 18-19, 114-16
(Oct) 31-3
(Nov) 30, 109-12
(Dec) 28-9, 89-90

Maternal Welfare
MUNFORD, RS: Care of the infant in Utero (Aug) 56-8

Medical Assistants, Maryland Association of
(Jan) 75
(July) 18-19
(Aug) 29-30
(Oct) 119
(Dec) 35

Medical Education
Is the medical school philosophy responsible for the health-manpower shortage? (June) 38
Medical education (Feb) 54

Medical Ethics
History of medical ethics (Feb) 60-1
Medical discipline (Feb) 101-2
NELSON, HA: Medical ethics—choice for right (Feb) 64-7
Objectives of the program on medical ethics (Feb) 59
On medical ethics (editorial) (Feb) 57
PEARSON, HL: Medical ethics and some of its problems (Feb) 68-71
PEEPLES, WJ: A house divided against itself . . . (June) 114-16
Principles of medical ethics (Feb) 62-3
Professional courtesy (Jan) 12
SARGEANT, J: Guidelines laid down (Jan) 53
WILEY, HW: We are carefully to preserve that life which the author of nature has given us, for it was no idle gift (Oct) 65

Medical Examiners (see Medicolegal)

Medical News
(Mar) 72-4
(Aug) 42-4
(Sept) 86-8
(Oct) 89-90
(Nov) 32-5
(Dec) 25-6

The month in Washington
(Jan) 38-40
(Feb) 21-3
(Mar) 44-5
(Apr) 11-13
(May) 15-17
(June) 25-7
(July) 47-8
(Aug) 45-6
(Sept) 46-7
(Oct) 47-8
(Nov) 27-9
(Dec) 25-6

Medical Professionalism
BLASINGAME, FJL: Problems of a free health market (July) 71-6
HARLOW, RF: Public relations for the doctor (Jan) 63-5
MEANS, JH: Homo medicus Americanus (Feb) 91-100
Physician/pharmacist code of cooperation (Feb) 76-8
Professionalism (Feb) 89-90
TERRY, CL, JR: Physician as a defendant in discipline (Feb) 103-6

Medical Societies, Component
(Jan) 123-39
(Feb) 42-6
(Mar) 114-18
(Apr) 140-2
(May) 45
(June) 37
(July) 6, 17
(Aug) 15
(Sept) 48
(Oct) 123-9
(Nov) 143-4

Medicine
AMA Physician's placement service (Mar) 87-90
ARCHAMBAULT, RF: Threat to medicine (Mar) 51
BEAZLEY, RM: Medical officer at 90° south (Mar) 52-5
BEHNEMAN, HMF: Leaves from a doctor's notebook a century ago (Dec) 63-6
Use of terms medical center or medical clinic (Feb) 87
WILBUR, DL: March of medicine 1923-1968 (Apr) 69-75

Medicolegal
AMPAC Fellowship established (July) 31
Council on legislative activities: it analyzes proposed medical legislation (July) 41-2
GORRELL, J: Why the physician should write . . . and to whom (July) 107-9
KING, JF: Office dos and don'ts from a legal standpoint (Dec) 67-70
Medicolegal code of cooperation (Feb) 72-5
REAP, BR: Medicolegal: the incident report (Jan) 81
WILSON, EF, RS FISHER: Medical examiner system in Maryland—an ideal system (Dec) 51-62
WOODHOUSE, GA: Relation of grievance committees and state boards of medical examiners (Feb) 107-109

Mental Hygiene
CARSON, JE, K GORWITZ: Capacity, patient population size and occupancy rates (Oct) 103
Employee-patient ratios (Dec) 85
Fact sheet for 1968 fiscal year (Sept) 91
National scene (Aug) 119
Report to the 15 southern states (Nov) 83
CYTRYN, L: Role of the family physician in the prevention of emotional disorders in children (Aug) 90-7
TUERK, I, K GORWITZ: Hospitalized mentally subnormal (Jan) 82
Long term patient (May) 84
Maryland's mental hospitals 5 years after desegregation (July) 83
On Baltimore's mental health problems and needs (Apr) 130-1

Mental Retardation
PEEPLES, WJ: Recommendations concerning PKU diagnosis, treatment and follow up (May) 89
Report of the ad hoc committee for the study of PKU legislation (Apr) 126-7

Nursing
Critical nurse shortage worsens (Apr) 137-8
DEMBO, DH: Nurse's role in cardiopulmonary resuscitation (Sept) 89-90
RN responsibilities and duties as related to medical practice act (Feb) 80-2
SCHAEFER, JF: Conference on nursing (Jan) 104-5
Statement on report on protocol on RN responsibilities and duties as related to the medical practice act (Feb) 79

Nutrition
ENLOE, CF, JR: Are we well fed? Who knows? (May) 91-2

Neurology
HECK, AF: Basic mechanisms of transient ischemic attacks (May) 70-2
PRICE, TR: Neurological manifestations of heart disease, (Nov) 103-4

Obesity
AMA warns of potential hazards in "Health Club" reducing programs (May) 22-3
Diet pill scandal: is an ethics committee review of the local situation needed? (May) 63
SOLOMON, N: Studying and treating the obese patient (May) 64-9

Pediatrics

ANDERSON, W: Preventive pediatrics—a new look (Aug) 70-4

BERUBE, LW: Why a pediatrics symposium (Aug) 54-5

CYTRYN, L: Role of the family physician in prevention of emotional disorders in children (Aug) 90-7

DELANEY, DW: Acute infections of respiratory tract of children (Aug) 75-81

FARBER, RE: Child lead paint poisoning still prevalent (June) 137-8

KAPPELMAN, MM: Recent concepts about the newly born (Aug) 59-63

LONDON, RL: Diagnosis and management of bronchial asthma (Aug) 82-9

MUNFORD, RS: Care of the infant in utero (Aug) 56-8

NEILL, CA: Progress in pediatric cardiology (June) 117-18

SCHAFFER, AJ: Future aspect of child health care in Baltimore (Sept) 98-9

STINE, OC: Changes in the supply of physicians giving office medical care to children (Jan) 66-9

Family rehabilitation as an objective of comprehensive care for children (Apr) 96-100

TOLSON, RE: Care of the neonate and infant (Aug) 64-9

Population Explosion

Population may explode again within 10 years (July) 121

Psychiatry

FARBER, RE: Psychiatric day center (Dec) 84

Pulmonary Disease

Chronic bronchitis and emphysema (Nov) 107-8

DELANEY, DW: Acute infections of the respiratory tract of children (Aug) 75-81

Quackery

Chiropractic labelled unscientific (Dec) 98

Quackery is world-wide threat (Dec) 101

Rehabilitation

CARROLL, DG: Cardiac rehabilitation, part III—follow up after myocardial infarction (Jan) 78-9

Measurement of performance in rehabilitation:
(June) 132-3
(July) 84-6
(Aug) 113-16
(Sept) 127-30
(Oct) 107-10
(Nov) 81-2
(Dec) 81-3

Vocational rehabilitation (Mar) 85-6

LEWIS, KB: Cardiac rehabilitation, part IV—a coronary care unit (Feb) 130-2

STINE, OC: Family rehabilitation as an objective of comprehensive care for children (Apr) 96-100

Reproduction

Human reproduction (Jan) 36-7

Sex Education

PAXSON, M: Role of the physician in sex education (Aug) 98-105

Skin

SCALIA, SP: Histoplasmin skin test survey in Baltimore County (Mar) 56-60

Steiner

The Steiner inheritance (Jan) 58-9

Tuberculosis

BEACHAM, EG: 1st year review of alcoholism program, TB division, Baltimore City Hospital (Aug) 108-110

Chemoprophylaxis for the prevention of TB (June) 121-3

Infectiousness of TB (May) 79-80

RILEY, RL: The hazard is relative (Apr) 108-9

Vaccines

Vaccines: a success story (Feb) 15

Woman's Auxiliary

(Jan) 90
(Feb) 125
(Mar) 99-100
(Apr) 113
(May) 103-5
(June) 143-5
(July) 111
(Sept) 117-120
(Oct) 29-30
(Nov) 116-17
(Dec) 87-8

AUTHOR INDEX

ACTON, C: Detoxification of the alcoholic patient (Sept) 123-6
ANDERSON, W: Preventive pediatrics—a new look (Aug) 70-4
ARCHAMBAULT, RF: Carthagina delendenda esse (editorial) (Apr) 68
Threat to medicine (Mar) 51

BALL, P: Some apparently common problems in patients receiving contraceptive pills (Apr) 91-5
BAYLESS, TM: Gastrointestinal hemorrhage (Sept) 72-4
BEACHAM, EG: 1st year review of alcoholism program. TB division, Baltimore City Hospitals (Aug) 108-110
BEAZLEY, RM: Medical officer at 90° south (Mar) 52-5
BEHNEMAN, HMF: Leaves from a doctor's notebook a century ago (Dec) 63-6
BENACK, RT: Role of extended care facilities, nursing homes and personal care homes in the care of the chronically ill (July) 77-80
BERGHUIS, JW: Metastasis and development of malignancy in benign colonic polyps (Jan) 60-2
BERUBE, LW: Why a pediatrics symposium (Aug) 54-55
BLASINGAME, FJL: Problems of a free health market (July) 71-6

CARROLL, DG: Cardiac rehabilitation, part III—follow up after myocardial infarction (Jan) 78-9
Measurement of performance in rehabilitation
(June) 132-3
(July) 84-6
(Aug) 113-16
(Sept) 127-30
(Oct) 107-10
(Nov) 81-2
(Dec) 81-3
Specialty in search of identity (May) 73-6
CARSON, JE, K GORWITZ: Capacity, patient population size and occupancy rates (Oct) 103
Employee-patient ratios (Dec) 85
Fact sheet for 1968 fiscal year (Sept) 91
National scene (Aug) 119
Report to the 15 southern states (Nov) 83
CHAPMAN, P: Hippie talk: from acid to zap (Oct) 66-7
COHEN, AR: Certification and the GP (Aug) 107
COHEN, BS: Osteoarthritis (Apr) 152-5
CONRAD, ME: Factors affecting the body iron content (Apr) 76-90
COYNE, DH: Journal advertising—yes or no? (Nov) 42
CYTRYN, L: Role of the family physician in the prevention of emotional disorders in children (Aug) 90-7

DE HOFF, JB: Prevention and treatment of alcoholism: impracticable—low priority program? (May) 81-3
DELANEY, DW: Acute infections of respiratory tract of children (Aug) 75-81
DEMBO, DH: Nurse's role in cardiopulmonary resuscitation (Sept) 89-90

EDDY, NB, et al: Drug dependence: its significance and characteristics (Oct) 57
ENLOE, CF, JR: Are we well fed? Who knows? (May) 91-2

FARBER, RE: Baltimore City Health Dept
(Jan) 74
(Mar) 77
(Apr) 112
(Nov) 105-6
Child lead paint poisoning still prevalent (June) 137-8
Family planning clinics (Aug) 121
Infant immunization report (July) 89
Preventing teen pregnancies (May) 87-8
Psychiatric day center (Dec) 84
Public health in Baltimore in 1967 (Feb) 128-9
Reducing teen-age pregnancy (Oct) 91
FARNSWORTH, DL: Drug problem among young people (Oct) 81-5
FISHER, RS: See EF WILSON

GASTINEAU, CF: Care of unstable diabetes (July) 68-70
GORDIS, L: See MM MARKOWITZ
GORRELL, J: Why the physician should write . . . and to whom (July) 107-9
GORWITZ, K: See JE CARSON; I TUERK
GOTT, VL: Current status of priming solutions for pump oxygenators (Sept) 68-9

HARLOW, RF: Public relations for the doctor (Jan) 63-5
HECK, AF: Basic mechanisms of transient ischemic attacks (May) 70-2
HILL, CL: Cryosurgery and its application to ear, nose, and throat surgery (Jan) 54-7
HUMPHRIES, JO: New methods for the prevention and treatment of ventricular arrhythmias (Mar) 75-6

JACKSON, DP: Hemorrhagic disease (Sept) 70-1
Indications for platelet transfusions (Sept) 78-9

KAPPELMAN, MM: Recent concepts about the newly born (Aug) 59-63
KING, JF: Office dos and don'ts from a legal standpoint (Dec) 67-70

LECHNER, CB: Journal advertising—yes or no? (Nov) 41
LEE, YC: Vectorcardiography (Aug) 111-12
LEVIN, J: Diagnosis and treatment of the hemophilias (Sept) 75-7
LEWIS, KB: Cardiac rehabilitation, part IV—a coronary care unit (Feb) 130-2
LONDON, RL: Diagnosis and management of bronchial asthma (Aug) 82-9
LUBASH, GD: Renin-angiotension system and hypertension (Feb) 112-14

MARKOWITZ, MM, L GORDIS, R RODRIGUEZ: Problems in preventing initial attacks of rheumatic fever (Jan) 72-3

MC LAUGHLIN, JS: Heart transplantation (July) 91-2
MEANS, JH: Homo medicus Americanus (Feb) 91-100
MILLER, WR, AA SERPICK: Use of platelet transfusion in the treatment of leukemia (Sept) 80-3
MORSE, EE: Survey of blood use in Baltimore (Sept) 57-8
MUNFORD, RS: Care of the infant in utero (Aug) 56-8

NEILL, CA: Progress in pediatric cardiology (June) 117-18
NELSON, HA: Medical ethics—choice for right (Feb) 64-7

OKEN, F: Maryland's Alcoholism Control Law and the general hospital (Dec) 71-4

PAXSON, M: Role of the physician in sex education (Aug) 98-105
PEARSON, HL: Medical ethics and some of its problems (Feb) 68-71
PEEPLES, WJ: State of Maryland Department of Health
(Jan) 76-7 (July) 101-2
(Feb) 115-16 (Aug) 117-18
(Mar) 81-2 (Sept) 101-2
(Apr) 125 (Oct) 99-101
(June) 130-1 (Dec) 79-80
A house divided against itself . . . (June) 114-16
Recommendations concerning PKU diagnosis, treatment and follow up (May) 89
PERT, JH, et al: Laboratory and clinical results with improved methods of preparing fresh and frozen platelet concentrates (Sept) 84-5
PINCOCK, CS: Our turbulent youth (Oct) 58-64
PRESNALL, LF: Folklore and facts about employees with alcoholism—part II (Jan) 95-9
PRICE, TR: Neurological manifestations of heart disease (Nov) 103-4

RANDALL, L: Unwed teen-age mother (Feb) 145-6
REAP, BR: Medicolegal: the incident report (Jan) 81
RICHARDS, RD: Temporal arteritis: a cause of blindness (July) 64-7
RILEY, RL: The hazard is relative (Apr) 108-9
RODRIGUEZ, R: See MM MARKOWITZ
RUTHERFORD, RB: Current concepts in the use of whole blood in the management of hemorrhagic shock (Sept) 65-7

SARGEANT, J: Executive Secretary's Newsletter:
(Jan) 17-18 (July) 9-10
(Feb) 17-18 (Aug) 9-10
(Mar) 17-18 (Sept) 9-10
(Apr) 17-18 (Oct) 9-10
(May) 9-10 (Nov) 9-10
(June) 9-10 (Dec) 9-10
Guidelines laid down (editorial) (Jan) 53
Your medical faculty at work:
(Jan) 71 (July) 81-2
(Feb) 110-11 (Aug) 106
(Apr) 101 (Oct) 87-8
(May) 77-8 (Nov) 36
(June) 101-4 (Dec) 75-6

SCALIA, SP: Histoplasmin skin test survey in Baltimore County (Mar) 56-60
SCHAEFER, JF: Chloromycetin (chloramphenical): a "fall guy"! (Oct) 49
Conference on nursing (Jan) 104-5
Generic prescribing (July) 62-3
SCHAFFER, AJ: Future aspect of child health care in Baltimore (Sept) 98-9
SCHERLIS, L: Death: the diagnostic dilemma (Dec) 77-8
SCHOOLMAN, LR: A gamut of "collagenoses" (Mar) 70-1
SERPICK, AA, WR MILLER: Use of platelet transfusion in the treatment of leukemia (Sept) 80-3
SHENKMAN, M: Family physician and alcoholism (July) 87-8
SOLOMON, N: Studying and treating the obese patient (May) 64-9
SPARGER, CF: Straight pin ingestion in an American indian boarding school (Nov) 43-7
STINE, OC: Changes in the supply of physicians giving office medical care to children (Jan) 66-9
Family rehabilitation as an objective of comprehensive care for children (Apr) 96-100

TERRY, CL, JR: Physician as a defendant in discipline (Feb) 103-6
TOLSON, RE: Care of the neonate and infant (Aug) 64-9
TUERK, I: Attitudes and alcoholics (Apr) 110-11
Hospitalized mentally subnormal (Jan) 82
Long term patient (May) 84
Maryland's mental hospitals 5 years after desegregation (July) 83
On Baltimore's mental health problems and needs (Apr) 130-1
One Man's view of alcoholism and the alcoholic (June) 119-20

VALERI, GR: Clinical effectiveness of concentrated liquid stored red cells and previously frozen red cells (Sept) 59-64

WEIGAND, DA: Alopecias—diagnostic and pathogenetic considerations (Mar) 61-9
WEISMAN, MN: Use of disulfiram in the treatment of alcoholism (Mar) 83-4
WILBUR, DL: March of medicine 1923-1968 (Apr) 69-75
WILEY, HW: We are carefully to preserve that life which the author of nature has given us, for it was no idle gift (Oct) 65
WILSON, EF, RS FISHER: Medical examiner system in Maryland—an ideal system (Dec) 51-62
WISWELL, JG: Hyperthyroid heart disease (Oct) 97-8
WOODHOUSE, GA: Relation of grievance committees and state boards of medical examiners (Feb) 107-9
WURMSER, L: Drug addiction and drug abuse (Oct) 68-80

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title ot article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number, the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.



after surgery...

To restore tissue depletion of Vitamin B Complex and ascorbic acid induced by the physiological stress of surgery, illness or injury—Increases the recuperative power of convalescence.

beta massive capsules

B COMPLEX WITH VITAMIN C



Thiamin	HCl	10 mg.
Riboflavin	B_2	10 mg.
Pyridoxine HCl	B_6	5 mg.
Cyanocobalamin	B_{12}	4 mcg.
Ascorbic Acid	C	150 mg.
Calcium Pantothenate		20 mg.
Niacinamide		50 mg.

ERL

EASTERN RESEARCH LABORATORIES, INC.

302 S. CENTRAL AVE. BALTIMORE, MARYLAND 21202

Whenever anxiety induces or intensifies clinical symptoms

Librium®
(chlordiazepoxide HCl)

Quickly relieves anxiety~Helps improve response in psychophysiologic disorders~Seldom impairs mental acuity or physical coordination,on proper dosage~ Has wide margin of safety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.

ROCHE

Roche®
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Also available: ***Libritabs***™ *(chlordiazepoxide) 5-mg, 10-mg, 25-mg tablets*

WI
MA791



RECEIVED
FEB 27 1969

Maryland State Medical Journal

AL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

VOLUME 18, NUMBER 2
FEBRUARY 1969

BETHESDA MD 20
9600 ROCKVILLE

Something new has been added...

American College of Physicians | American College of Surgeons | American Hospital Association | American Medical Association

THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

has accredited

TAYLOR MANOR HOSPITAL

for 3 years

which has been surveyed and meets the standard for hospitals of The Joint Commission on Accreditation of Hospitals. For providing high quality medical and hospital care in all services and for maintaining as its primary objective the safety and welfare of the patient, this certificate of accreditation is granted by the authority of the Joint Commission on Accreditation of Hospitals.



It has been gratifying to know that the high standards we have always taken for granted have received national recognition on our first voluntary application.

You as a physician can now have added confidence in our continual efforts on your patients behalf.

Irving J. Taylor, M.D.
MEDICAL DIRECTOR

Taylor Manor Hospital

Ellicott City, Maryland 465-3322

A Licensed Psychiatric Hospital

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

- LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.
- Literature on indications and dosage available on request.
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)

Maryland State Medical Journal

VOLUME 18 FEBRUARY 1969 NUMBER 2

EDITOR

C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD

E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, MD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

CONTENTS:

Special Report on Traffic Safety Legislation—
Editorial—Too Much Too Late, John Sargeant 46
Ten Commandments for Safer Driving, Bill Johnston 48
Maryland Law and the Drinking Driver, Rudiger Breitenecker, MD 49
Implied Consent—And What It Implies, from a speech by J. Dudley Digges 51

Present Status of Permanent Pacing of the Heart, Victor Parsonnet, MD 57
Emergency Treatment of Acute Pulmonary Edema, Philip Samet, MD 59
Clinical Application of Beta-Adrenergic Receptors with Propanolol, Morris Stampfer, MD, Stephen E. Epstein, MD 61
Evaluation of Left Ventricular Myocardial Function in Patients Undergoing Cardiac Surgery, Joseph W. Linhart, MD 63

DEPARTMENTS:

Traffic Safety—Your Patient's Life—How Can You Protect It? 54
Your Medical Faculty at Work, John Sargeant 65
Heart Page—Pulmonary Function Testing in the Office, Richard W. Blide, MD 67
Maryland State Department of Mental Hygiene—Voluntary Admissions ... 69
Alcoholism Section—A View From the Bottom of the Bottle 79
Rehabilitation Notes—Prediction of Performance of Patients with Hip Fracture, #2 83
Baltimore City Health Department—"Your Family Doctor" 85
Library Page—The Art of Medicine 89

Doctors Take Note **5** Executive Secretary's Newsletter **9** Annual Meeting Program **12** Computer Death Predictions **17** Annual Meeting Speakers **23** MEDIC **25** The Month in Washington **31** Medical News **43** Accessions to the Library **90** Woman's Auxiliary **91** Component Society News **97** Book Reviews **99** Modular Room to Provide Germ-Free Environment **102** AMA Concern About Physician Supply Dates Back 50 Years **107** Volunteer Physicians for Vietnam **113** Dead for an Hour, Animals Revive **114** Medical Students Aid Hard-Core Addicts **117** Classified Advertising **118** Advertising Index **119** Information for Authors **120**

ON THE COVER: The gory remains of a Porche dominate the cover this month to remind everyone of the importance of the pending traffic safety legislation presently before the General Assembly. We are indebted to **Russell S. Fisher, MD,** Chief Medical Examiner, State of Maryland, for supplying the cover photo. The driver did not survive to give his consent to the usage.

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland.

Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

OFFICERS OF
THE MEDICAL AND CHIRURGICAL SOCIETY

President: Arthur G. Siwinski, MD
President elect: Russell S. Fisher, MD
First Vice President: Henry A. Briele, MD
Second Vice President: Wolcott L. Etienne, M
Third Vice President: George O. Eaton, MD
Secretary: William A. Pillsbury, MD
Treasurer: Karl F. Mech, MD

COUNCILORS

Western District

Archie R. Cohen, MD—1969
Henry V. Chase, MD—1969

Central District

Robert C. Kimberly, MD—1969
William Carl Ebeling, MD—1970
John Collins Harvey, MD—1970
John F. Schaefer, MD—1970
William G. Speed, III, MD—1970
J. Arthur Weinberg, MD—1970
John T. Chissell, MD—1971
John M. Dennis, MD—1971
J. Morris Reese, MD—1971
Harry M. Robinson, Jr., MD—1971
Donald J. Roop, MD—1971

Eastern District

Arthur T. Keefe, MD—1970
Raymond M. Yow, MD—1971

Southern District

Manning W. Alden, MD—1969
J. Parran Jarboe, MD—1971

South Central District

William B. Hagan, MD—1969
Henry P. Laughlin, MD—1970
John G. Ball, MD—1971
Wolcott L. Etienne, MD—1971
Seruch T. Kimble, MD—1971

Terms of office expire at conclusion of annual meeting

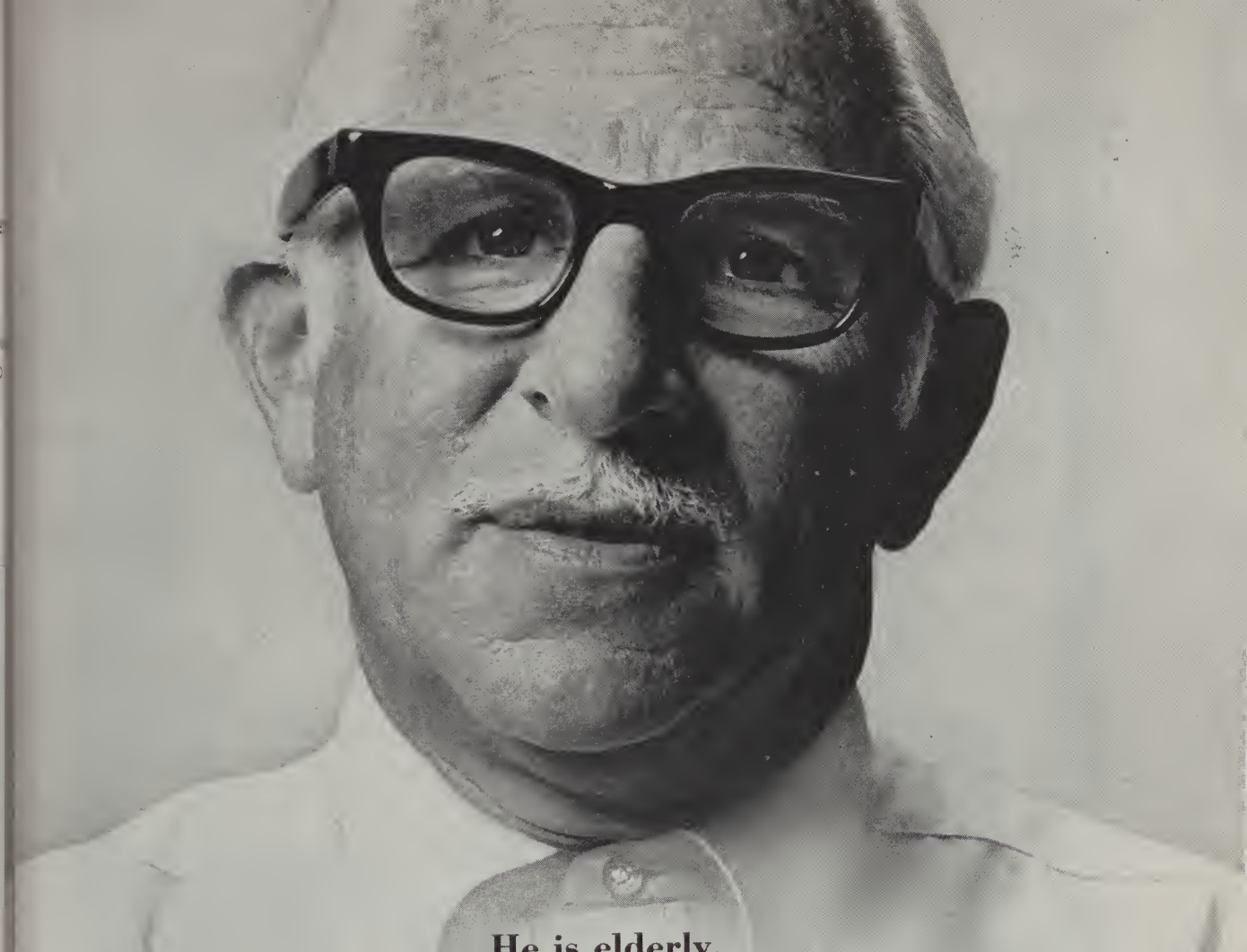
DELEGATES TO THE
AMERICAN MEDICAL ASSOCIATION

Russell S. Fisher, MD—1969
J. Sheldon Eastland, MD—1970
Robert vL. Campbell, MD—1971

ALTERNATES:

M. McKendree Boyer, MD—1969
Robert C. Kimberly—1970
Charles F. O'Donnell, MD—1971

Terms of office expire at end of calendar year



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

guard susceptible patients against intestinal monilial overowth during broad-spectrum therapy—the protection of ystatin is combined with demethylchlortetracycline in ECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN the broad-spectrum therapy that prevents monilial ergrowth.

fectiveness: Because its antibacterial component is DECLOMYCIN emethylchlortetracycline, DECLOSTATIN should be equally or more ective therapeutically than other tetracyclines in infections caused by racycline-sensitive organisms. The antifungal component, Nystatin, otects against superinfection by antibiotic-resistant fungal overgrowth articularly monilia) in the intestinal tract.

ntraindication: History of hypersensitivity to demethylchlortetracyne or nystatin.

arning: In renal impairment, usual doses may lead to excessive accumation and liver toxicity. Under such conditions, lower than usual doses e indicated, and, if therapy is prolonged, serum level determinations ay be advisable. A photodynamic reaction to natural or artificial sunght has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction which may range from erytema to severe skin manifestations. In a smaller proportion, photoergic reactions have been reported. Patients should avoid direct posure to sunlight and discontinue drug at the first evidence of skin scomfort. Necessary subsequent courses of treatment with tetracynes should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

Doctors take note...

MARCH 3-7, 1969
AMERICAN COLLEGE OF PHYSICIANS/UNIVERSITY OF CINCINNATI COLLEGE OF MEDICINE

Postgraduate Course—The Doctor, His Patient and the Illness (Psychiatric Approach to Problems of Importance to Internists): Cincinnati General Hospital, Cincinnati, Ohio. Co-Directors: William Ransohoff, MD, Paul H. Ornstein, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

MARCH 3-7, 1969
NEW YORK UNIVERSITY MEDICAL CENTER

Symposium—Arthritis and Related Disorders: New York University Medical Center, 550 First Ave., New York, N.Y. Chairmen: Edward C. Franklin, Edward F. Hartung, Thomas G. Kantor, Martin Meltzer. Contact: Office of the Recorder, New York University Post-Graduate Medical School, 550 First Ave., New York, N.Y. 10016.

MARCH 3-7, 1969
UNIVERSITY OF PENNSYLVANIA/DIVISION OF GRADUATE MEDICINE

Postgraduate Course—Pulmonary Physiology: University of Pennsylvania School of Medicine, Philadelphia, Pa. Contact: Office of the Director, Division of Graduate Medicine, University of Pennsylvania, 237 Medical Laboratories Building, Philadelphia, Pa. 19104.

MARCH 6-8, 1969
THE ASSOCIATION FOR CHILDREN WITH LEARNING DIFFICULTIES

Convention: Tarrant County Convention Center, Fort Worth, Texas. General Session Speaker: Herbert G. Birch, MD, associate research professor of pediatrics, Albert Einstein College of Medicine, N.Y. Chairman: Joseph B. Hall. Contact: Mr. Hall, P.O. Box 8456, Fort Worth, Texas 76112.

MARCH 10-12, 1969
AMERICAN COLLEGE OF SURGEONS

Sectional Meeting—Joint Meeting for Physicians and Nurses: Sheraton-Boston and Statler-Hilton, Boston, Mass. Chairmen: Bentley P. Colcook, MD, physicians; Miss Kathryn L. O'Donnell, R.N., nurses. Contact: Mr. T. E. McGinnis, Manager of Exhibits and Meeting Arrangements, American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

MARCH 10-21, 1969
UNIVERSITY OF PENNSYLVANIA/DIVISION OF GRADUATE MEDICINE

Postgraduate Course—Pulmonary Diseases: University of Pennsylvania School of Medicine, Philadelphia, Pa. Contact: Office of the Director, Division of Graduate Medicine, University of Pennsylvania, 237 Medical Laboratories Building, Philadelphia, Pa. 19104.

MARCH 15, 1969
THE AMERICAN ACADEMY OF ALLERGY

Postgraduate Course—Basic Concepts in Human Hypersensitivity: Americana Hotel, Bal Harbour, Fla. (Part of the 25th Annual Meeting, see below for more information.)

MARCH 16, 1969
THE AMERICAN ACADEMY OF ALLERGY

Postgraduate Course—Allergy-1969: Americana Hotel, Bal Harbour, Fla. (Also part of the 25th Annual Meeting.)

MARCH 17-19, 1969
THE AMERICAN ACADEMY OF ALLERGY

25th Annual Meeting: Americana Hotel, Bal Harbour, Fla. Speakers: Dr. René Dubos, professor and member of Rockefeller University; Dr. Harrison Brown, professor of geochemistry and professor of science and government, California Institute of Technology. Contact: The American Academy of Allergy, Executive Office, 756 North Milwaukee St., Milwaukee, Wisc. 53202.

MARCH 17-21, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Recent Advances in Cardiovascular Disease: The Mount Sinai Medical Center, Blumenthal Auditorium, New York, N.Y. Director: Charles K. Friedberg, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 18, 1969
PHI DELTA EPSILON FRATERNITY

Annual Lecture—The Pathogenesis of Diabetes: 11:30 PM, Wilson Hall, University of Maryland Hospital, Baltimore, Md. Speaker: David M. Kipnis, MD, professor of medicine, Washington University School of Medicine, St. Louis, Mo. Chairman: Ronald Goldner, MD.

MARCH 18, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conference—Diagnosis and Management of Renal Injuries: 4 PM, University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. 21201.

MARCH 19, 1969
MARYLAND KIDNEY FOUNDATION

Seminar in Renal Disease—A Hypothesis of the Mechanism of Action of Diuretic Compounds: 5 PM, University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. Speaker: Richard H. Kessler, MD, professor of medicine, Northwestern University, and director of research, Veterans Administration Research Hospital, Chicago, Ill.

MARCH 21, 1969
AIR POLLUTION CONTROL ASSOCIATION/MID-ATLANTIC STATES SECTION

Semiannual Technical Conference—What's in the Wind—Meteorological Aspects of Air Pollution Control: Drexel Institute of Technology, Philadelphia, Pa. Contact: Stephen C. Brown, Environmental Sciences Coordinator for Tenneco Chemicals, Inc., 280 Park Ave., New York, N.Y. 10017.

MARCH 21-22, 1969
AMA COUNCIL ON RURAL HEALTH

22nd National Conference—Meeting Rural Health Needs in Our Changing Times: Philadelphia Marriott Motor Hotel, Philadelphia, Pa. Contact: Bond L. Bible, PhD, Council on Rural Health, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

MARCH 22-23, 1969
AMERICAN PSYCHIATRIC ASSOCIATION COMMITTEE ON PSYCHIATRY AND MEDICAL PRACTICE

8th Colloquium—Problems and Issues in Communication and Collaboration Between Psychiatrists and Other Physicians: Hilton Hotel, Pittsburgh, Pa. Speakers: Maynard Shapiro, MD, president of the American Academy of General Practice; Frank Kiesler, MD, director of the Northland Mental Health Center; Mr. Harry Henderson, editor of the World Wide Medical News Service. Coordinator: Rex A. Pittenger, MD. Contact: Dr. Pittenger, c/o GP Education Project, 1700 Eighteenth St. N.W., Washington, D.C. 20009.

MARCH 24-28, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Modern Pathology for Internists: University of Pittsburgh School of Medicine and Presbyterian University Hospital, Pittsburgh, Pa. Co-Directors: Robert S. Totten, MD, William Cooper, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 26-28, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Three Days of Gastroenterology: Emory University, Atlanta, Ga. Director: John T. Galambos, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 28-29, 1969
AMA COUNCIL ON MEDICAL SERVICE AND DIVISION OF HEALTH SERVICE

3rd National Congress on the Socio-Economics of Health Care—Major Issues in Health Care: The Challenge to Medicine: Palmer House, Chicago, Ill. Contact: Council on Medical Service, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

MARCH 31-APRIL 2, 1969
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

20th Symposium—Psychiatry and the Internist: Host Farm Resort Motel, Lancaster, Pa. Directors: Paul Jay Fink, MD, Wilbur Oaks, MD. Contact: Sage Cordell, Assistant Director, Continuing Education, Hahnemann Medical College and Hospital, Department of Medicine, 230 N. Broad St., Philadelphia, Pa. 19102.

We Also Repair Jewelry

In our own shop, the same skilled craftsmen who create our fine jewelry also do the repairs.

For this type of work you will find our prices in line—even less in many instances.

If a stone needs to be re-set, if a pin is broken, if a ring is to be made larger or smaller—these jobs are just as welcome as an elaborate re-mount. Feel free to consult us.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

FEBRUARY CLEARANCE



. . . The label that leaves no doubt

EXCLUSIVE REPRESENTATIVE — OLEG CASSINI

Maryland's oldest and largest furrier
225 N. HOWARD ST.
LE 9-4900

Mano Swartz

We recommend CAMP

PENDULOUS ABDOMEN SUPPORTS



Specifically designed to balance the load of forward bulk in obese patients; affords relief of strain on muscles and ligaments of the back and feet in the ankle-joints, caused by weight-accented spinal curve, bowed head and rounded shoulders. These supports often improve circulation and digestive disturbances.

DONALD O. FEDDER, ORTHOTIST

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

BALTIMORE, MD.

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.

executive secretary's newsletter

February, 1969

UNION PAY SCALE COMPARISON

It was brought to our attention recently that an appliance repair man charged $12 for a house visit. Parts to effect a repair totalled another $17, making a total charge of $29; somewhat more than the physician makes for a house call.

Spurred by this comparison, we present below the rates and the totals for varying work weeks that skilled tradesmen receive:

Carpenters, $4.82 per hour, union rate

Electricians, $5.45 per hour, union rate

Plumbers, $5.21 per hour, union rate

Linotype Operators, $4.50 per hour, union rate

Bricklayers, $5.80 per hour, union rate, including fringe benefits

Based on time and a half for every hour over 40 hours, the weekly wage would be: (Linotype workers have a 36 hour, 40 minute basic work week):

	ANNUAL WAGE		
	40 hours	60 hours	80 hours
Carpenters	10,025	17,544	25,063
Electricians	11,336	19,843	28,350
Plumbers	10,837	18,970	27,103
Linotype Oprs.	9,750	16,770	23,790
Bricklayers	11,232	19,656	28,080

In larger cities than Baltimore, such as New York, basic hourly wage rates are comparatively higher.

According to the latest Medical Economics Survey, the average physician works anywhere from 60, 70 to 80 hours per week.

PALM AND TURN CONTAINER

Information has been received from the Maryland Poison Control Center that a new "Palm and Turn" container has been on the market for over a year.

Physicians are urged to ask pharmacists to use this type of container as it is felt that routine use would prevent many toxic ingestions by children.

REFERENCE COMMITTEE MEETING

The Reference Committee will meet on

THURSDAY, MARCH 20, 1969

at 8:00 p.m., in the Faculty building, at which time any resolutions for consideration by the Annual Session of the House of Delegates will be discussed. All members in good standing are invited to attend this session.

MED-CHI RETIREMENT FUND

The net asset value of the Med-Chi Members Retirement Fund has increased 22.05% for the period January 1, 1968, through November 31, 1968.

PUBLIC SPEAKING COURSE

A one-day public speaking course will be held under the auspices of the Public Relations Committee of the Faculty on Thursday, March 13, 1969, from 9:00 a.m. to 5:00 p.m. Registration is limited and those interested should contact the Faculty office promptly to indicate their wish to attend.

CONGRESS ON SOCIOECONOMICS OF HEALTH CARE

The third national Congress on the Socioeconomics of Health Care has been scheduled for March 28 and 29, at the Palmer House, Chicago, Illinois. Full details may be obtained from the AMA or the Faculty office.

LEGISLATIVE NOTE

Three bills in which the Faculty has more than usual interest have been assigned numbers by the General Assembly. House Bill 27 is the Revised Medical Practice Act; Senate Bill 75 is the Implied Warranty Proposal that would define blood transfusion as a service rather than a product; and Senate Bill 149 provides for the Incorporation of Self-Employed Persons. The latter two bills have been referred to the Senate's Economic Affairs Committee, while HB 27 has been referred to the House Judiciary Committee.

Those physicians wishing to testify in behalf of any of these bills should contact the Faculty office for hearing dates and times.

John Sargeant
Executive Secretary

YOUR NUMBER MAY BE UP

DOCTOR

◆

IT WILL BE FALSE ECONOMY
NOT TO BE ADEQUATELY
PREPARED

◆

YOUR
INCOME TAX RETURNS

MUST

BE SUPPORTED BY
ADEQUATE RECORDS

◆

OUR SERVICE OFFERS YOU

MAXIMUM CONTROL AND SAFETY
FROM BALANCING RECORDS AND
MINIMUM EFFORT ON YOUR PART

◆

FINANCIAL MANAGEMENT
CAN HELP YOU

◆

DIAL 752-5920

Professional Management Co.

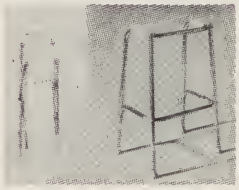
914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN

WE RENT AND SELL





Hospital and Convalescent Equipment

Wide selection of everything needed for patient care in the hospital or at home.

Manual Vari-Hite Hospital Beds
Hydraulic Lifters
Automatic Electric Stair-Glides
Wheel Chairs
Diathermy Machines
Infra-Red Heat Lamps
Ultra-Violet Sun Lamps
Invalid Walkers
Traction Apparatus

MEDICARE FORMS

We have the necessary Medicare forms, and will assist your patients in processing the required information concerning items purchased or rented from us.



Murray-Baumgartner

SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.
Phone: 669-9300 Baltimore, Md. 21216

ANNUAL MEETING PROGRAM

Wednesday, April 9

The Alcazar

9:30 AM—Meeting of the House of Delegates

1:30-5 PM—Scientific Session

Official Investigation of Sudden, Suspicious and Violent Deaths—A Community Responsibility. **Milton Helpern, MD,** New York

Intrasynovial Corticosteroid Therapy in Arthritis. **Joseph Lee Hollander, MD,** Philadelphia

Diagnostic Techniques and Procedures in Detection of Cervical Cancer. **Howard W. Jones, MD,** Baltimore

Detection of Head and Neck Cancer. **Robert H. Johnson, Jr., MD,** Baltimore

The Belvedere Hotel

6-7 PM—Hospitality Night for all members of the Faculty and their wives

The Alcazar

8:30 PM—Medicolegal Symposium: Concerning Malpractice

Thursday, April 10

The Alcazar

9:30 AM-Noon—Scientific Session

Medical Grand Rounds. **Theodore E. Woodward, MD, and Medical Staff of the University of Maryland,** Baltimore

The Place and Function of a Community Hospital as a Center for Graduate and Continuing Education. **Robert L. Evans, MD,** York, Pennsylvania

Noon—Election of the Board of Medical Examiners

The Belvedere Hotel

12:30 PM—Annual Luncheon

The Alcazar

2:30-5 PM—Scientific Session

Surgical Grand Rounds. **George D. Zuidema, MD, and Surgical Staff of The Johns Hopkins University,** Baltimore

Experiences with Cardiac Transplantation in Man. **Denton A. Cooley, MD,** Houston

The Belvedere Hotel

6:15 PM—Annual Presidential Reception and Banquet

Guest Speaker: **Burtis E. Montgomery, MD,** Harrisburg, Ill., Chairman, Board of Trustees, American Medical Association

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

Friday, April 11

The Alcazar

9:30 AM-Noon—Scientific Session

Coronary Care Panel. **Leonard Scherlis, MD,** Baltimore, Moderator

Panelists:

Present Status and Future Projections:
Leonard Scherlis, MD

Treatment of Tachyarrythmias:
Kenneth B. Lewis, MD, Baltimore

Treatment of Bradyarrythmias:
Elijah Saunders, MD, Baltimore

Organization and Training Needs:
Jerry Salan, MD, Baltimore

Osler Hall—Faculty Building, 1211 Cathedral Street

2 PM—Meeting of the House of Delegates

On *SATURDAY, APRIL 12,* all physicians are invited to attend the *medical* and *pediatric grand rounds* in the new Turner Auditorium at The Johns Hopkins University School of Medicine.

* * * * * *

SCIENTIFIC AND TECHNICAL EXHIBITS AT THE ALCAZAR

Wednesday, Thursday, and Friday

Intermissions will be provided to visit these exhibits which constitute a symposium on therapeutic progress.

(See page 24 for a list of the Technical Exhibitors)

* * * * * *

PLAN TO ATTEND
MARK THESE DATES ON YOUR CALENDAR

APRIL 9, 10, 11, 1969

no gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

n case you're curious, back in the 1700's paregoric was eing used for diarrhea, but since the state of the pharmaeutical art was extremely primitive, fungus growth in ne medication was a problem. Bitter-tasting camphor as added to prevent such growth and anise oil was dded in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not ontain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 r 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's ule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID

IPC
REG. U.S. PAT. OFF.

INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

120968

MEDICAL AND CHIRURGICAL FACULTY

OF THE STATE OF MARYLAND



MED-CHI

Members Retirement Plan

TRUSTEE AND ADMINISTRATOR

Mercantile-Safe Deposit and Trust Company

INVESTMENT ADVISOR

T. Rowe Price and Associates, Inc.

LIFE UNDERWRITER

Shenandoah Life Insurance Company

FOR MORE INFORMATION DETACH AND MAIL SLIP DIRECTLY TO:

MED-CHI MEMBERS
RETIREMENT PLAN
1211 Cathedral Street
Baltimore, Maryland 21201

Name .....

Address .....

City ..... State ..... Zip Code .....

Telephone Number ..... Date of Birth .....
(month) (day) (year)

Computer Death Predictions

Help Reduce Hospital Deaths

Physicians at Pacific State Hospital use a computer to ascertain which ones among their patients run a relatively high risk of death in the early months after admission—and have found these projections help to prevent death.

Patients entering the hospital, which is dedicated exclusively to the treatment of the mentally retarded, are tested and data about them is set up on permanent files in a computer system. As the files began to build, physicians noted that patients with certain characteristics were more likely to die while hospitalized than others, especially within the first few months after admission.

A computer program was developed to study the several variables—age, sex, intelligence quotient, type of illness—to determine which patients ran a high death risk. The computer found the highest risk was among children under five years of age with IQ's of less than 30. (Normal IQ is 100). The findings were that 13% of these children died within six months of admission and that 20% died within four years.

"We believe one of the causes of this may have been the shock these children experienced in being taken from the atmosphere of the home and being placed in the hospital—coupled with the fact that their physical condition usually is somewhat poor," said Richard K. Eyman, PhD, a psychologist and director of computer operations at the hospital.

"When we began this study, we found 133 per thousand of these young, low-IQ children were dying within six months of admission," Dr. Eyman said. "With the computer's help, we reduced this figure to 23 per thousand in ten years by sending these projections to the hospital staff.

Dr. Eyman said computerized death predictions could be applied to hospitals other than those that handle the mentally retarded.

"The great advantage of the computer is that it does not miss anything. In the course of admitting patients, a human could miss a relationship between certain symptoms. But the computer will not—if it has been properly programmed," he said.

Dr. Eyman is director of the Socio-Behavioral Study Center for Mental Retardation at the hospital. He directs a variety of computer-oriented research projects into mental retardation with a $3-million, seven-year grant from the National Institute of Mental Health.

The computer keeps records on 13,000 patients —all those who have entered the hospital since its founding in 1927. The present patient population is 2,800—ranging from infants to the elderly.



Insurance For The Doctor

PROFESSIONAL LIABILITY*

Workmen's Compensation
Equipment Floater
Bonds on Employees
Public Liability
Fire Insurance
Disability Income
Term Life Insurance
Pension Plans

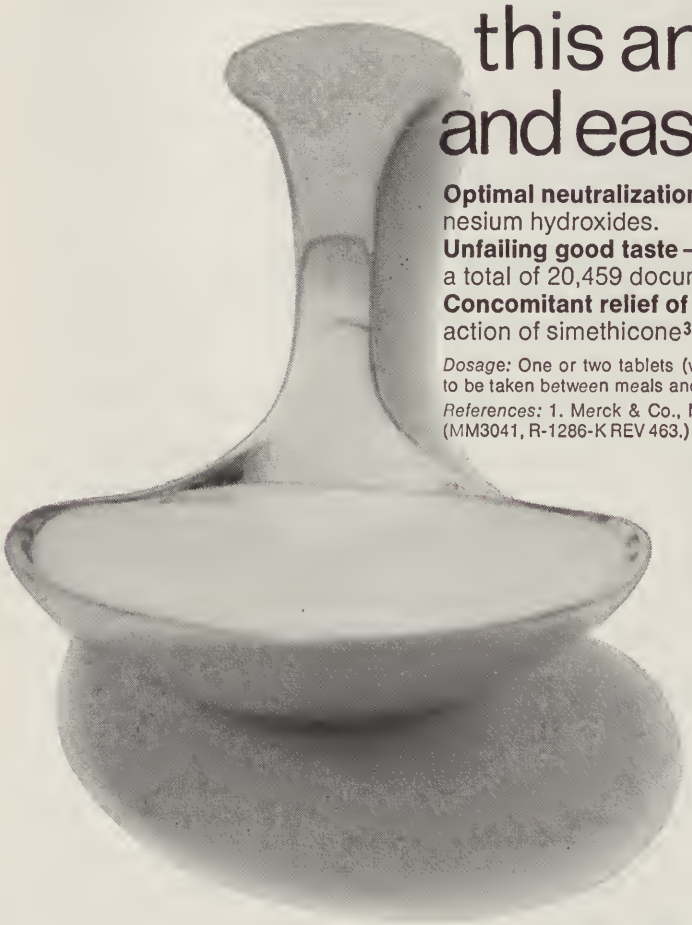
* *Endorsed by MEDICAL SOCIETY OF D. C. & MD.*

Russell, Marsh & Kennedy, Inc.

5151 WISCONSIN AVE. WASHINGTON, D. C. 20016 244-7600

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. 93:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109



"Man's best friend" in wintertime diarrheas

In winter "flu" and viral gastroenteritis, Donnagel (4 oz. size!) can bring aid and comfort to sufferers from both diarrhea and its discomforts because it contains kaolin and pectin plus belladonna alkaloids (as in Donnatal®). Donnagel treats the whole diarrhea problem. Available on your prescription or recommendation. A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

CLEAR THE TRACT!
ROBITUSSIN®



THERE'S A FORMULATION FOR EVERY COUGHING NEED

All five members of the Robitussin family contain glyceryl guaiacolate. This outstanding expectorant agent increases the output of lower respiratory tract fluid (R.T.F.) Increased R.T.F. volume thins mucus, thereby improving the action of bronchial and tracheal cilia and making thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"

ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Alcohol, 3.5%

For unproductive, allergic coughs

ROBITUSSIN A-C® (exempt narcotic)
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Pheniramine maleate ..... 7.5 mg.
Codeine phosphate ..... 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Non-narcotic for 6-8 hour cough control

ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate ..... 100 mg.
Dextromethorphan hydrobromide .... 15.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"

COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate ..... 50 mg.
Dextromethorphan hydrobromide .. 7.5 mg.

Clears sinuses and nasal stuffiness as it relieves cough

ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl quaiacolate ..... 100 mg.
Phenylephrine hydrochloride ..... 10.0 mg.
Alcohol, 1.4%

	Robitussin	Robitussin A-C	Robitussin-DM	Cough Calmers	Robitussin-PE
Expectorant	●	●	●	●	●
Demulcent	●	●	●	●	●
Cough Suppressant		●	●	●	
Antihistamine		●			
Non-Narcotic	●		●	●	●
Long-Acting (6-8 Hours)			●	●	
Nasal, Sinus Decongestant					●

PHOTO BY VICTOR HAND

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

MAKE YOUR HOTEL ROOM RESERVATIONS NOW

for the

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

APRIL 9, 10, 11, 1969

A block of rooms has been set aside at the BELVEDERE HOTEL, Baltimore, for those attending this meeting. Because of many activities in the city, rooms will be at a premium.

The rates are $19.00 for a double or twin bedded room for two persons; single occupancy rate is $15.00; and suites are $25, $30, and $40.00.

FOR YOUR HOTEL RESERVATION DETACH AND MAIL THIS SLIP DIRECTLY TO:

Mrs. Jacqueline Amati
BELVEDERE HOTEL
Charles & Chase Sts., Balto., Md. 21202

Name .....

Address ..... City ..... State .....

Please reserve ..... rooms Approximate rate ..... No. of persons .....

Date of arrival ..... Date of departure .....

Attending Annual Meeting of the Medical and Chirurgical Faculty.
All requests subject to confirmation.

171st Annual Meeting

More prominent speakers * who will present papers during the Annual Meeting in April include Denton A. Cooley, MD, and George D. Zuidema, MD.

Denton A. Cooley, MD, world-renowned heart surgeon, will speak on *Experiences with Cardiac Transplantation in Man* during the Annual Meeting of the Medical and Chirurgical Faculty on Thursday, **April 10,** at the Alcazar in Baltimore.



Dr. Cooley

Dr. Cooley, who was born in Houston, was graduated from the University of Texas and in 1944 received his MD degree from The Johns Hopkins University School of Medicine. He served a surgical internship and residency at the Hopkins, followed by a year as senior surgical registrar in thoracic surgery at Brompton Hospital for Chest Diseases in London.

A member of the Board of Governors of the American College of Surgeons, the Board of Thoracic Surgery and the Board of Regents of the American College of Chest Physicians, Dr. Cooley is currently professor of surgery at Baylor University College of Medicine, chief of cardiovascular surgery at St. Luke's Episcopal Texas Children's Hospital, physician-in-chief of the Texas Heart Institute, attending surgeon at the Methodist Hospital and the Ben Taub General Hospital in Houston, and consultant in cardiovascular surgery at several Veterans Administration Hospitals in Texas.

Among the over 20 honors and awards which have been bestowed on Dr. Cooley are:

Ten Outstanding Young Men in the United States—U.S. Jr. Chamber of Commerce

Humanitarian Award—Variety Clubs International

Distinguished Alumnus Award—University of Texas

Rene Leriche Prize (for the most significant contribution to cardiovascular surgery)—International Surgical Society

Distinguished Achievement Award—*Modern Medicine*

Surgical Grand Rounds will be presented at the Alcazar on Thursday afternoon, **April 10,** by **George D. Zuidema, MD,** and the **surgical staff of The Johns Hopkins.** Dr. Zuidema since 1964 has been professor and director, department of surgery, The Johns Hopkins University School of Medicine, and surgeon-in-chief, The Johns Hopkins Hospital.



Dr. Zuidema

After receiving his MD at The Johns Hopkins in 1953, he served a straight surgical internship, an assistant residency in surgery, and was chief resident surgeon at the Massachusetts General Hospital. In 1959, Dr. Zuidema was a teaching fellow in surgery at Harvard Medical School. Following this he was assistant professor, then associate professor of surgery at the University of Michigan Medical School until 1964 when he came to Baltimore. Dr. Zuidema has held, and still holds, many consultant appointments among which are membership on the Science and Technology Advisory Committee and the Medical Advisory Council for manned space flight, and editor of the *Journal of Surgical Research.* The awards and scholarships received by him, and the society memberships and visiting professorships, are too numerous to list.

* See the December and January Journals for capsule biographies of **Robert L. Evans, MD, Howard W. Jones, Jr., MD, Milton Helpern, MD,** and **Joseph Lee Hollander, MD,** who also will be featured during the scientific sessions of Annual Meeting in April.

THE EXHIBITS—A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM

ANNUAL MEETING—APRIL 9, 10, 11, 1969 at the Alcazar

TECHNICAL EXHIBITORS

(as of February 1, 1969)

Abbott Laboratories
American Medical Building Guild, Inc.
Ayerst Laboratories
Baltimore Dictating Machine Company
Bristol Laboratories
Brookes Research Associates
Ciba Pharmaceutical Company
Herbert Cox, Correct Shoes
Doctors Supply Company
Encyclopaedia Britannica, Inc.
Endo Laboratories, Inc.
Graymar Company
Hummel-Rhode & Co.
Knoll Pharmaceutical Company
Lakeside Laboratories, Inc.
Lederle Laboratories
Eli Lilly and Company
Maryland Blue Cross and Blue Shield Plans
Maryland Pharmaceutical Association
Mead Johnson Laboratories
Med-Chi Insurance Trust
Med-Chi Members Retirement Plan
Medco Products Company
Merck Sharp & Dohme
The Wm. S. Merrell Company
C. V. Mosby Co. and Yearbook
Murray-Baumgartner Surgical Instrument Co.
Pfizer Laboratories
Physicians Nutritional Services, Inc.
Wm. P. Poythress & Co., Inc.
J. B. Roerig Division, Chas. Pfizer & Co., Inc.
William H. Rorer, Inc.
Sandoz Pharmaceuticals
W. B. Saunders Company
G. D. Searle & Co.
Skill Surgical, Inc.
Smith, Miller & Patch, Inc.
E. R. Squibb & Sons
Syntex Laboratories, Inc.
Warner-Chilcott Laboratories
Wyeth Laboratories

A. H. Robins Company, Geigy Pharmaceuticals, and Hynson, Westcott & Dunning, Inc. have made contributions, although they are unable to have exhibits this year.

Offering 2 GENERATIONS of research and experience in cooperation with the MEDICAL PROFESSION

CORRECT SHOES

for every Rx need

Normal	Pronators
Straight	Supinators
Corrective	D. B. Splints

Modifications and Custom Work

HERBERT COX

HU 4-0021	SA 7-7883
1433 Reisterstown Rd.	210 N. Liberty St.
Pikesville 21208	Baltimore 21201

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

MEDIC 1969 SCHEDULE

OF POSTGRADUATE PROGRAMS

presented through

Medical Education's Dedicated Instructional Channel

Supported in part by The Medical and Chirurgical Faculty and a grant from Merck, Sharp and Dohme.

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Prince George's General, Cheverly
Provident, Baltimore
Rosewood State, Owings Mills
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
South Baltimore General, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Washington County, Hagerstown

Other Locations:

Medical and Chirurgical Faculty, Baltimore
State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
539-0872

or

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201 383-3010 Ext. 8722

MARCH 7, 1969—12:30 P.M.

G.I. BLEEDING

Marvin M. Schuster, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine, and
Assistant Chief of Medicine,
Baltimore City Hospitals

A practical approach to the diagnosis and treatment of gastrointestinal hemorrhage will be discussed. This will include both the acute massive bleed as well as chronic hemorrhage and will emphasize diagnostic technicalities which have been found useful.

Sponsor: Easton Memorial Hospital
Replays: Monday, March 10, 1969 12:30 P.M.
Wednesday, March 12, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

MARCH 14, 1969—12:30 P.M.

THE PATIENT WITH DIARRHEA— MALABSORPTION SYNDROME

Vernon M. Smith, MD
Professor of Clinical Medicine and Head
Department of Medicine,
Mercy Hospital

Diarrhea is a common disorder which usually is benign, self-limited and requires no treatment. Persistent diarrhea, on the other hand, may denote important underlying disease, including malabsorption. The talk will be directed toward a logical distinction among the malabsorption syndromes, according to their underlying pathophysiological states; and toward the practical management of patients suspected of having malabsorption syndrome.

Sponsor: Prince George's General Hospital
Replays: Monday, March 17, 1969 12:30 P.M.
Wednesday, March 19, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

(Continued next page)

MARCH 21, 1969—12:30 P.M.

ABDOMINAL PAIN

David Skinner, MD

Assistant Professor of Surgery
The Johns Hopkins University School of Medicine

The differential diagnosis of upper abdominal pain includes common conditions such as hiatal hernia, ulcer, pancreatitis, pancreatic carcinoma, biliary tract disorders, aortic aneurysms, and ischemic mesenteric vascular disease. Physiologic and radiographic tests useful in establishing specific diagnoses will be described, and indications for surgical or medical treatment will be presented.

Sponsor: Cumberland Memorial Hospital

Replays: Monday, March 24, 1969 12:30 P.M.
Wednesday, March 26, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

MARCH 28, 1969—12:30 P.M.

CANCER OF THE BREAST

Edward F. Lewison, MD

Assistant Professor of Surgery
The Johns Hopkins University School of Medicine

A review of the historical and epidemiologic aspects of breast cancer will be presented. Prompt detection and diagnosis will be discussed. Treatment will be considered from the standpoint of both the operable patient and the inoperable patient with advanced or metastatic disease.

Sponsor: Frederick Memorial Hospital

Replays: Monday, March 31, 1969 12:30 P.M.
Wednesday, April 2, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

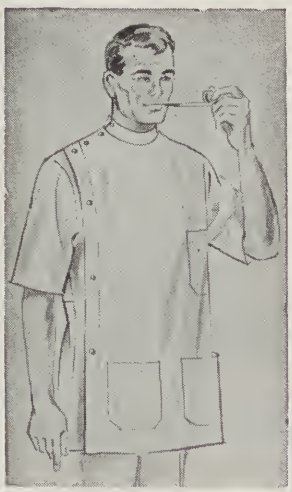
MEDIC 1968-1969 STANDARD WEEKLY PROGRAM SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8						
9			LECTURE REPLAY			PEDIATRIC GRAND ROUNDS J.H.H.
AM 10						
11						MEDICAL GRAND ROUNDS J.H.H.
11:30		MEDICAL GRAND ROUNDS U. OF M.				
NOON 12						
12:30	LECTURE REPLAY				MEDIC LECTURE	
1						
1:30						
2			LECTURE REPLAY		NEUROLOGY GRAND ROUNDS U. OF M.	
3						
PM 4	PEDIATRIC GRAND ROUNDS - J. H. H.					
5						
6						
7						
8			LECTURE REPLAY			
9						

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#800—100% Nylon Taffeta **$5.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only
Sizes 34 to 46



- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46

Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**



MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

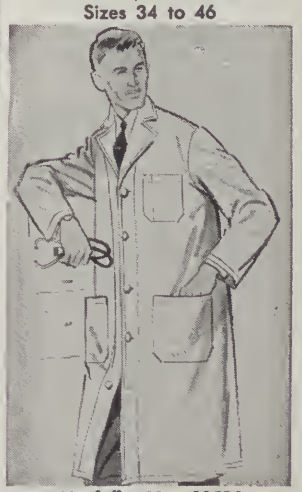
Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab. **$9.99**

Sizes 28-40

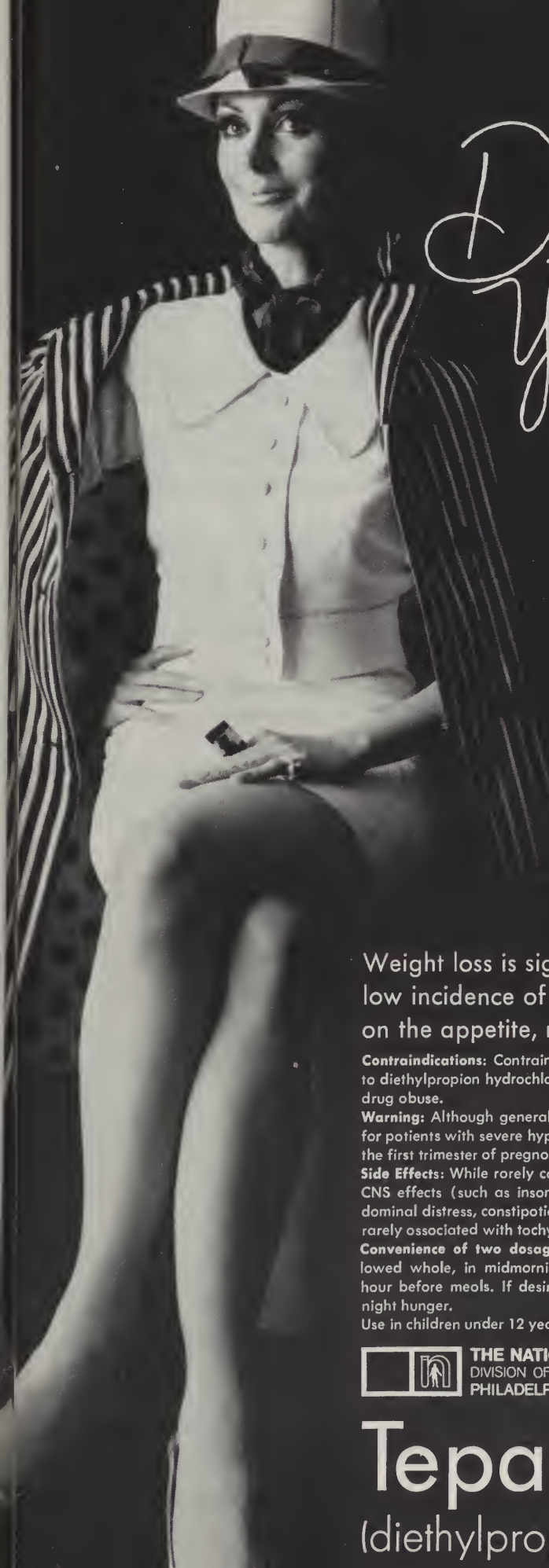


OTHER STORES IN

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639



Dear Doctor, You made me what I am today — a whole lot slimmer!

TEPANIL —the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Contraindicoted concurrently with MAO inhibitors, in potients hypersensitive to diethylpropion hydrochloride, ond in emotionally unstoble patients known to be susceptible to drug obuse.

Warning: Although generally sofer thon the omphetomines, use greot coution when prescribing for potients with severe hypertension or severe cardiovosculor diseose. Should not be used during the first trimester of pregnoncy unless potentiol benefits outweigh potentiol risks.

Side Effects: While rorely cousing theropy to be withdrown, side effects moy occur occosionolly; CNS effects (such as insomnio, nervousness, jitteriness), dryness of mouth, thirst, nausea, abdominal distress, constipotion, headoche, ollergic response including urticario or other dermatitis; rarely ossociated with tochycordio, cordioc orrhythmio or ECG chonges.

Convenience of two dosage forms: TEPANIL Ten-tab toblets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 o.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meols. If desired, on additionol tablet moy be given in midevening to overcome night hunger.

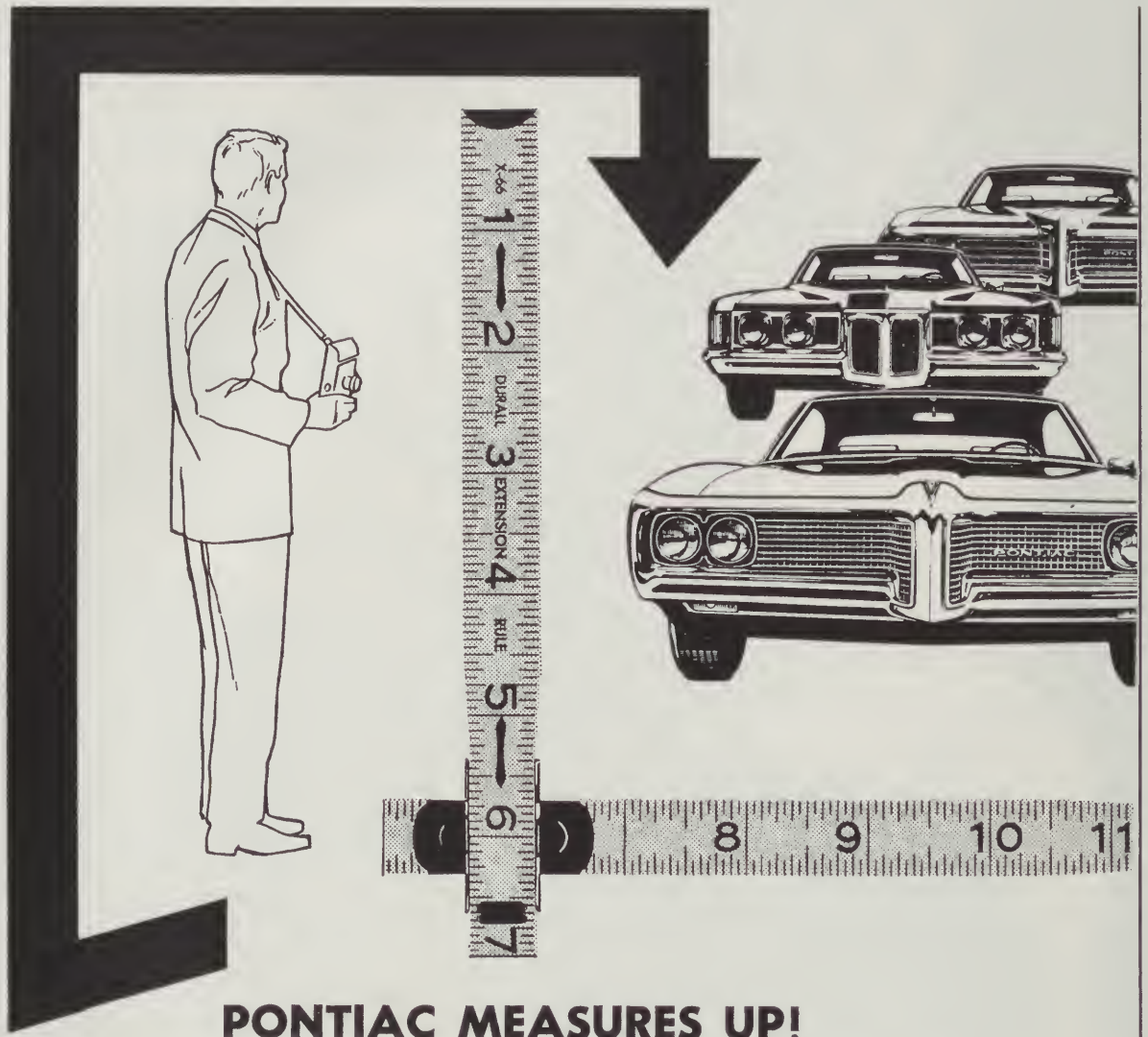
Use in children under 12 years of age is not recommended.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Tepanil® Ten-tab®

(continuous releose form)

(diethylpropion hydrochloride)



PONTIAC MEASURES UP!
KELLY PONTIAC MEASURES UP!

A great combination . . . the break-a-way 1969 Pontiac . . . from the dealer with the top deal in town.

Test Drive a '69 Pontiac real soon . . . at Kelly Pontiac!

KELLY PONTIAC

MARYLAND'S OLDEST AND LARGEST PONTIAC DEALER

5801 BELAIR ROAD AT WHITE AVENUE

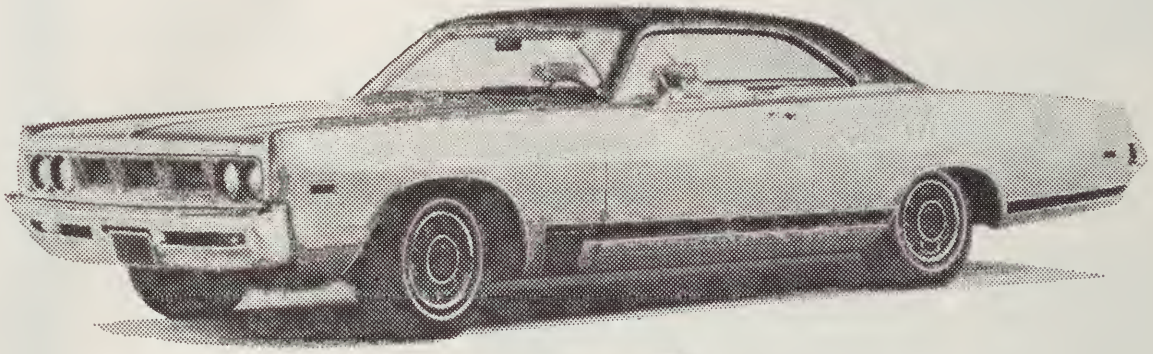
Save at Baltimore Federal

where
quarterly
dividends
give you
that
warm
comfortable
feeling



Open or add to your insured passbook savings account by the 10th and earn Baltimore Federal Savings & Loan Association's extra-high quarterly dividends for the whole month.

Downtown at Fayette & St. Paul Sts. • Eastpoint Shopping Center • Reisterstown Road Plaza
Towson at 7 Alleghany Ave. • Carney at 9609 Harford Road above Joppa • Yorktowne Plaza
Downtown Westminster at 6 East Main Street.



our
Final Net Figure
figures to
be lower on a
'69 DODGE

CENTRAL
DODGE
Baltimore's
Downtown Dodge Dealer
1111 Cathedral Street
Phone 685-3797



P.D.Q. SERVICE ESPECIALLY FOR DOCTORS *Professional, Dependable, Quick Auto Repairs. Our service department has instructions to give precedence to doctors in immediate, accurate electronic diagnosis and prompt, expert therapy on any make car to avoid unnecessary delay in your valuable service to the community.*

THE MONTH IN WASHINGTON

A House Ways and Means Committee member introduced on the first day of the new Congress a bill that would provide federal income tax credits to help individuals buy private health insurance.

The legislation (HR 19), sponsored by Rep. Richard Fulton (D., Tenn.), was similar in principle to a health insurance financing plan utilizing tax credits approved by the American Medical Association House of Delegates at San Francisco last June and reaffirmed at Miami Beach last December.

"Certainly before expanding any federal program, I believe it worthwhile to explore the use of the private sector and our tax system," Fulton said.

The Fulton bill provides that individuals with incomes of $2,500 or less and families with incomes of $5,000 or less would receive $150 vouchers from the federal government per eligible individual for the purchase of health insurance. The family maximum would be $400.

In the case of a taxpayer with an income between $2,500.01 and $5,000, or a family with an income between $5,000.01 and $7,500, the credit would be 75% per eligible individual with a maximum of $400 per family.

In the case of a taxpayer with an income of $5,000.01 to $7,500, or a family with an income between $7,500.01 and $10,000, the credit would be 50% per eligible individual with a $400 family maximum.

In the case of a taxpayer with an income exceeding $7,500.01, or a family with an income exceeding $10,000.01, the credit would be 25%.

At San Francisco, the House of Delegates adopted as approved AMA policy "the principle of graduated income tax credits for premiums paid for adequate health insurance." A resolution adopted at Miami Beach called upon the AMA to "vigorously promote the enactment of federal legislation implementing" the plan.

* * *

A special commission on health facilities concluded that government and private enterprise must cooperate to organize the nation's health resources into effective, efficient and economical community systems of comprehensive health care for all persons.

The National Advisory Commission on Health Facilities, established in October, 1967, drafted its report to the President in general terms and did not make any recommendations for legislation.

James Z. Appel, MD, a former president of the American Medical Association and a commission member, said the family physician would be the ideal "point of entry" to a community health system but there are not enough of them.

A summary of the report included:

"America's health care systems should combine private and public responsibility. Facilities and systems will vary from community to community in accordance with local capacities and local needs, but guiding principles should govern the effort to develop effective and efficient health care systems:

- These systems should be organized to assure appropriate points of entry into, and continuity of health care services.
- Every citizen should have ready access to quality health care.
- States, regions, local communities, and all health institutions should carry out continuous planning.
- Both those who provide and consume health services should participate in the decisions.
- All levels of health care should be interdependent."

* * *

A Health, Education and Welfare Department report to Congress recommended that preventive health care services not be added to medicare benefits at this time.

The report cited as reasons for the negative recommendation: administrative constraints, inability to estimate costs, limited experience with automated multi-phasic health screening, and an inadequate supply of health professionals.

The report was one of three requested by Congress last year and submitted before the change in Administration.

A second report dealt with coverage of mentally ill under medicare but did not include any recommendations.

The third reviewed qualifications of personnel under current medicare regulations. It stated that, because of an acute

manpower shortage in the field, physical therapists should be considered qualified if they could establish an adequate level of competency. HEW is developing a proficiency examination.

HEW recommended against allowing licensed practical nurses to serve as nurses responsible for the total nursing care at an extended care facility. It also recommended against changes in the regulations that set minimal standards for independent laboratory personnel.

* * *

The premium rate for medicare supplementary insurance covering physicians' fees (Plan B) will remain at the present rate, $4 each for the individual beneficiary and the federal government, until July 1, 1970.

The Johnson Administration's Secretary of Health, Education and Welfare, Wilbur J. Cohen, decided against an increase although the Social Security Administration's chief actuary had advised that an anticipated rise in physicians' fees called for an increase of 40 cents each for the beneficiary and the government.

Cohen again asked physicians to show "unusual restraint" in setting fees. He urged that physicians and patients cooperate "in eliminating unnecessary utilization of physicians' services," and asked carriers and intermediaries to carefully review claims during the next 18 months.

* * *

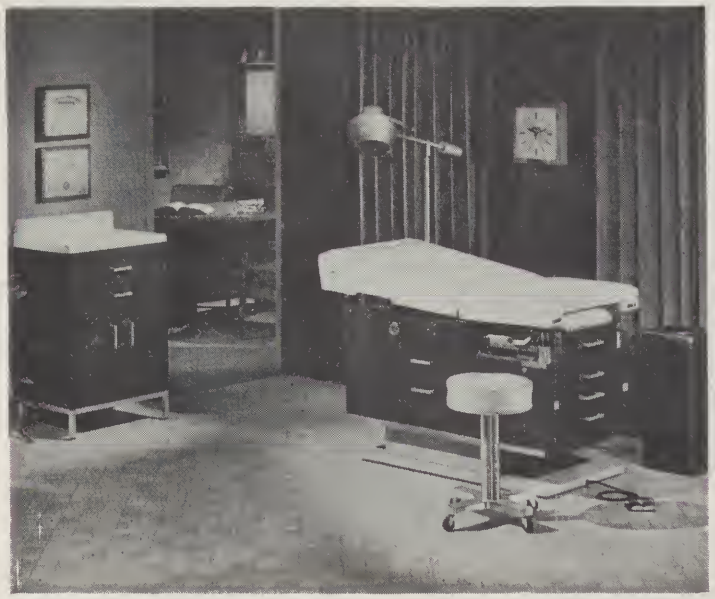
The Food and Drug Administration proposed that six widely prescribed antibiotic drug combinations be taken off the market on grounds that they fail to live up to their claims of effectiveness.

The drugs and their manufacturers: Albamycin G. U., Albamycin-T capsules and granules, and Panalba capsules, granules and drops—Upjohn Co.; Achromycin nasal suspension—Lederle Laboratories; Mysteclin F capsules, syrup and pediatric drops and Mysteclin F-125 capsules—E. R. Squibb & Sons Inc.

The drug companies were given 30 days to respond before FDA's final action. The FDA order could be appealed to the courts.

Two of the drug companies promptly protested the FDA proposal in public comments. An Upjohn spokesman said his company's combinations are superior to the major constituents alone. A Squibb spokesman said Mysteclin F had wide acceptance among physicians and a proper place in medical practice. A Lederle spokesman said Achromycin was not a major sales product, and declined to comment on what the company's official response would be.

CREATE THE PROPER PROFESSIONAL IMAGE



. . . in your patients' minds with a beautifully appointed office—professional and elegant decor—and equipped with the newest work-saving equipment. Engineered with your work day and patient load in mind—the Hi-Low Electric Examination Table brings your patient up to you with a touch of the toe, freeing both hands for sterile examinations.

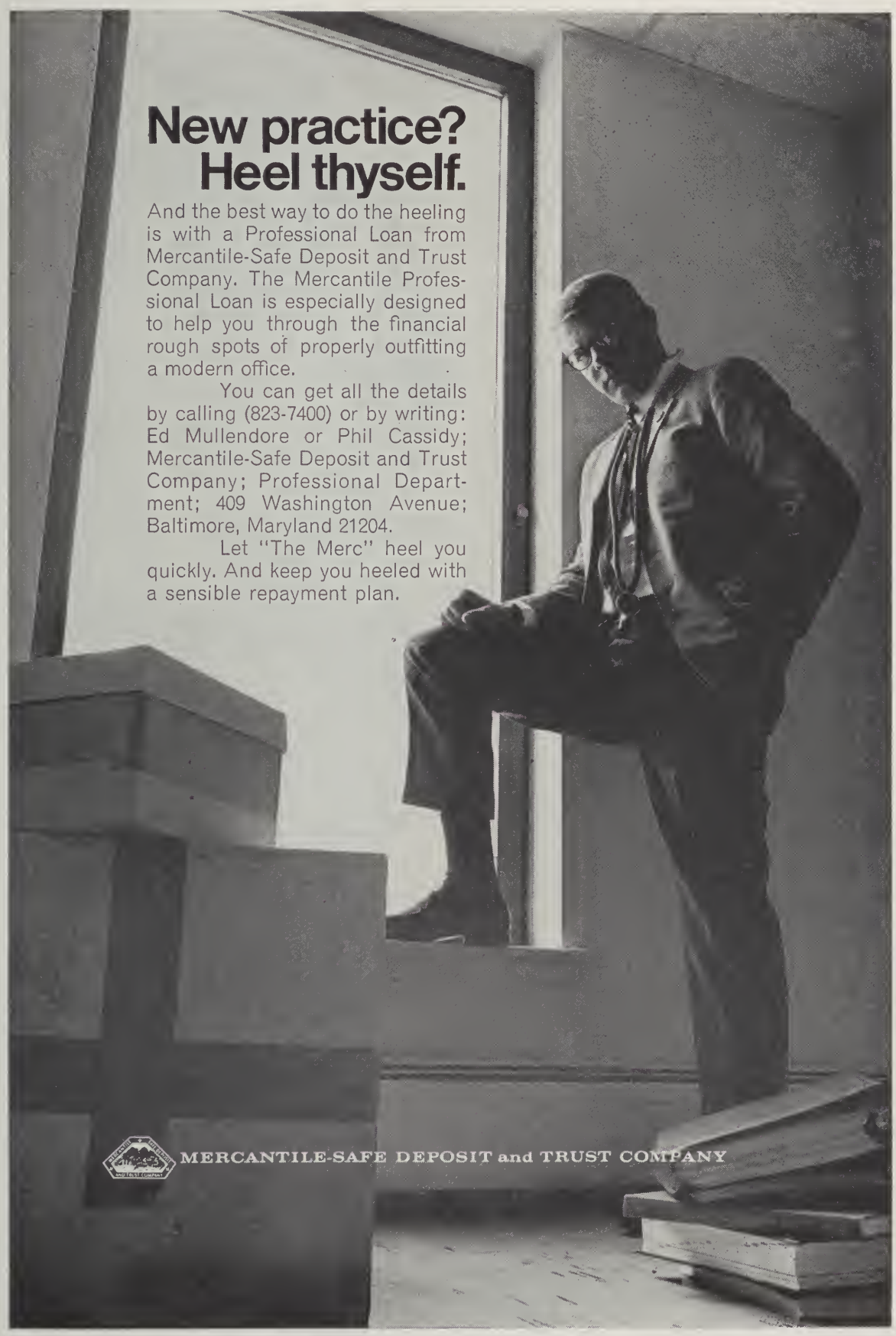
ASCO–amf plan

Small payments while you practice. Suite 66 (illustrated) for only $50.00 deposit—payments as low as $26.55 monthly for 60 months. All other professional needs including interior decorations, instruments and supplies, may be added. Call or write for details.

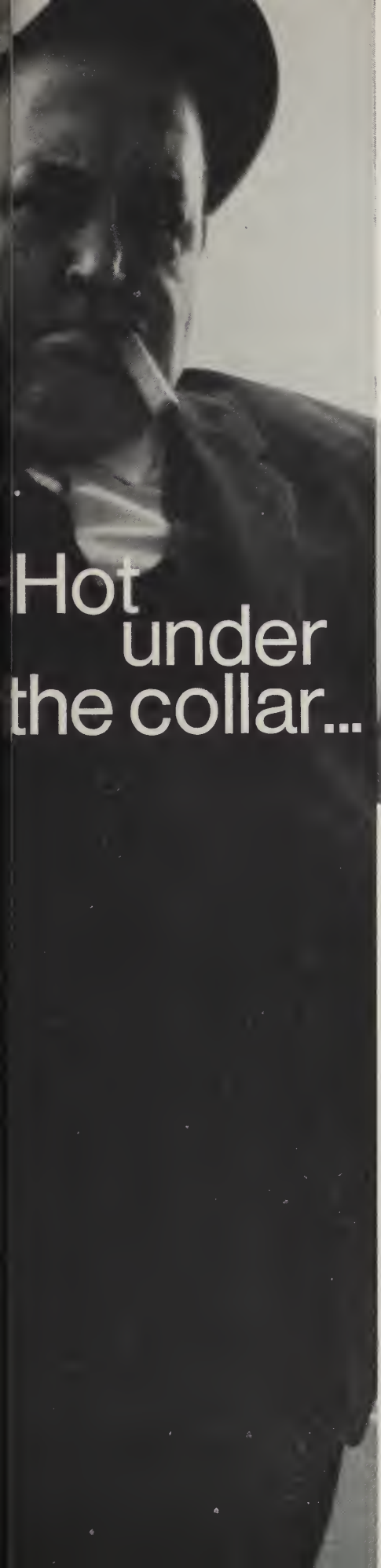
ACCREDITED SURGICAL COMPANY

MEDICAL AND SURGICAL SUPPLIES

8705 COLESVILLE RD. SILVER SPRING, MD. 20910 PHONE 585-7711 — BALTIMORE, MD. PHONE 792-9060


New practice?
Heel thyself.
And the best way to do the heeling is with a Professional Loan from Mercantile-Safe Deposit and Trust Company. The Mercantile Professional Loan is especially designed to help you through the financial rough spots of properly outfitting a modern office.
You can get all the details by calling (823-7400) or by writing: Ed Mullendore or Phil Cassidy; Mercantile-Safe Deposit and Trust Company; Professional Department; 409 Washington Avenue; Baltimore, Maryland 21204.
Let "The Merc" heel you quickly. And keep you heeled with a sensible repayment plan.
MERCANTILE-SAFE DEPOSIT and TRUST COMPANY





Hot under the collar...

high under the cuff.

Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000.
(B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

now she can cope...

hanks to

Butisol SODIUM®

SODIUM BUTABARBITAL)

he "daytime sedative" for everyday situational stress

/hen stress is situational—environmental pressure, orry over illness—the treatment often calls for an nxiety-allaying agent which has a prompt and redictable calming action and is remarkably well olerated. BUTISOL SODIUM (sodium butabarbital) eets this therapeutic need.

fter 30 years of clinical use . . . still a first choice mong many physicians for dependability, safety and conomy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to arbiturates.

Precautions: Exercise caution in moderate to severe epatic disease. Elderly or debilitated patients may eact with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative ose levels, skin rashes, "hangover" and systemic isturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 5 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

vailable for daytime sedation: Tablets, 15 mg. (¼ gr.), 0 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%). BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 5 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

IcNeil Laboratories, Inc., Fort Washington, Pa.



In childhood



Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

diarrheas...



- careful supervision
- electrolyte replacement
- specific anti-infective therapy

and...

LOMOTIL®

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contains:
diphenoxylate hydrochloride ..... 2.5 mg.
(Warning: May be habit forming)
atropine sulfate .....0.025 mg.

LOMOTIL, in conjunction with specifically indicated medical management, may be lifesaving in children with severe diarrhea.

Lomotil lowers the excessive intestinal propulsion characteristic of diarrhea. This reduction of precipitate intestinal flow allows a normal or more nearly normal reabsorption of fluid and electrolytes and counteracts the dehydration so hazardous to children.

Moreover, eight years' experience has demonstrated that Lomotil controls diarrhea with a minimum of unwanted secondary actions.

Senra del Valle and his associates[1] conducted a study of 477 children with diarrhea, most of whom were hospitalized with the disorder. Lomotil, used in 407 of the children, shortened the duration of the diarrhea.

Grinszpan, Goldstein and Divito[2] used Lomotil in 20 children with diarrhea and also reported a prompt disappearance of diarrhea. Harris and Beveridge[3] in a double-blind study of 50 children with diarrhea, however, found no clear pattern to suggest that Lomotil influenced the course of the condition.

Michener, Brown and Turnbull[4] added evidence supporting the beneficial effects of Lomotil in 80 children, concluding that Lomotil was highly useful in controlling abdominal cramping, diarrhea and hypermotility.

ıildren: Total Daily Dosage

3-6 mo. . . . ½ tsp.* t.i.d. (3 mg.)
6-12 mo. . . ½ tsp. q.i.d. (4 mg.)
1-2 yr. . . . . ½ tsp. 5 times daily (5 mg.)
2-5 yr. . . . . 1 tsp. t.i.d. (6 mg.)
5-8 yr. . . . . 1 tsp. q.i.d. (8 mg.)
8-12 yr. . . . 1 tsp. 5 times daily (10 mg.)
dults: . . . . 2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

ısed on 4 cc. per teaspoonful.

Maintenance dosage may be as low ıs one-fourth the initial daily dosage.

References:

1. Senra del Valle, A.; Linfante de Rufinelli, E. B.; Brumetti, E., and Rossi, R. H.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *127*:475-484 (Oct. 4) 1965. 2. Grinszpan, I. L.; Goldstein, A., and Divito, J.: El chlorhidrato de difenoxilato en las diarreas infantiles, Sem. Med. (Buenos Aires) *125*:758-763 (Aug. 27) 1964. 3. Harris, M. J., and Beveridge, J.: Diphenoxylate in the Treatment of Acute Gastro-Enteritis in Children, Med. J. Australia *2*:921-922 (Nov. 27) 1965. 4. Michener, W. M.; Brown, C. H., and Turnbull, R. B., Jr.: Ulcerative Colitis in Children. II. Medical and Surgical Therapy, Amer. J. Dis. Child. *108*:236-242 (Sept.) 1964.

SEARLE

Research in the Service of Medicine



THE BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144



tones down the "explosive gut"

helps restore normal motility and tone

CANTIL®

(mepenzolate bromide)

Diarrhea and other symptoms of common G.I. disorders can often be curbed with Cantil (mepenzolate bromide), bringing welcome relief to the harassed patient. Relatively specific for the hyperactive colon, it helps reduce diarrhea, pain and spasm with minimal effect on other viscera. Cantil (mepenzolate bromide) is indicated whenever these symptoms are associated with irritable colon, gastroenteritis, diverticulitis, and mild to moderate ulcerative colitis.

It is an anticholinergic drug without narcotic properties. Side effects are usually mild.

LAKESIDE

CONTRAINOICATIONS: Sensitivity to Cantil® (mepenzolate bromide), glaucoma, G.I. or G.U. obstruction, toxic megacolon. WARNINGS: Possibility of adverse reactions in advanced severe ulcerative colitis and atypical agitated reactions to phenobarbital in the elderly (Cantil with Phenobarbital). PRECAUTIONS: Cantil is of adjunctive use only; treatment of the underlying condition is indicated, be it organic or functional. Observe caution in conditions known to be incompatible with atropine-like drugs, e.g., open-angle glaucoma or prostatic hypertrophy. ADVERSE EFFECTS: Dry mouth; blurred vision; constipation; nausea; vomiting; bloating; dizziness; urinary retention. All are anticholinergic effects and usually tolerable. Habituation and idiosyncratic reactions to phenobarbital (Cantil with Phenobarbital) are possible, as is generalized rash. DOSAGE: One or two tablets three times a day and one or two at bedtime usually provide prompt relief. Cantil with Phenobarbital may be prescribed if sedation is required. HOW SUPPLIED: CANTIL (mepenzolate bromide)—25 mg. per scored tablet. Bottles of 100 and 250. CANTIL with PHENOBARBITAL—containing in each scored tablet 16 mg. phenobarbital (warning: may be habit forming) and 25 mg. mepenzolate bromide. Bottles of 100 and 250.

LAKESIDE LABORATORIES, INC., Milwaukee, Wisconsin 53201

The MEDICAL and CHIRURGICAL FACULTY of the State of Maryland

ACCIDENT AND HEALTH PROGRAM FOR FACULTY MEMBERS

- ACCIDENT AND SICKNESS TOTAL DISABILITY
- MAJOR MEDICAL EXPENSE
- ACCIDENTAL DEATH AND DISMEMBERMENT

Administered by
THE MED-CHI INSURANCE TRUST

Official Faculty Agent
B. Dixon Evander and Associates

Underwritten by
Hartford Accident and Indemnity Company

Member of
The Hartford Insurance Group
Hartford, Connecticut

For more information detach and mail slip directly to:

MED-CHI INSURANCE TRUST
1211 Cathedral Street, Baltimore, Maryland 21201

*Name*_____

*Address*_____

*City and State*_____ *Zip Code*_____

MEDICAL NEWS



During the rededication ceremony, marking the 20th anniversary of the "Your Family Doctor" television series on WMAR-TV, the station's assistant general manager, Robert B. Cochrane, received a plaque in gratitude for WMAR-TV's ". . . 20 years of Public Education in Preventive Medicine, Public Health and Safety on the Weekly TV Series. . . ." On hand for the commemoration program entitled "Souvenirs of 20 Years" were representatives of the Baltimore City Health Department and the Medical and Chirurgical Faculty of Maryland. From left to right the participants are: Jack Redfern, Chief of Community Health Information in the Baltimore City Health Department, who appears weekly as Dr. John Worthington in the series; Huntington Williams, MD, former Commissioner of Health, who helped inaugurate the program in 1948; Arthur G. Siwinski, MD, President of the Faculty, Robert E. Farber, MD, Commissioner of Health of Baltimore City; Emerson R. Julian, MD, chairman of the Health Committee of the Baltimore City Council, who represented the Mayor in presenting the plaque, and Mr. Cochrane.

* * *

Mary Ellen Avery, MD, Associate Professor of Pediatrics, The Johns Hopkins University School of Medicine, has been appointed Professor and Chairman of the Department of Pediatrics, Faculty of Medicine, McGill University, and Physician-in-Chief of the Montreal Children's Hospital.

Dr. Avery will assume her duties June 1, 1969, and will succeed Alan Ross, MD, who is retiring to become Founding Professor of Pediatrics at the new Medical School of University College, Nairobi, Kenya.

A 1952 graduate of The Johns Hopkins University School of Medicine, Dr. Avery is presently Pediatrician-in-Charge of the Newborn Nurseries at The Johns Hopkins Hospital.

* * *

Frederick M. Zerzavy, MD, a Fellow of the American College of Obstetrics and Gynecology, was recently appointed medical director of the outpatient department at Mount Sinai Hospital Medical Center in Chicago, and Associate Professor of Community Medicine and Assistant Professor of Obstetrics and Gynecology at the Chicago Medical School.

Dr. Zerzavy recently returned from a tour of duty in Viet Nam under the AMA's Volunteer Physicians Program.

* * *

The Sinai Hospital medical staff has elected the following officers for 1969: **Jerome Coller, MD,** attending physician in the Department of Medicine, is president; **Harold Sussman, MD,** a member of the Department of Surgery, vice-president; and **Sheppard Kaplow, MD,** of the Department of Anesthesiology, secretary-treasurer.

* * *

Paul Joliet, MD, Washington County Health Officer, recently became a member of the Faculty's subcommittee on Traffic Safety. He is also a member of the AMA Commission on Emergency Medical Services.

* * *

The newly elected president of the Medical Staff of Maryland General Hospital is **Charles E. Shaw, MD.** He succeeds **Stanley Bociek, MD,** who held the post last year.

Lloyd E. Saylor, MD, was elected vice-president and **Francis A. Clark, Jr., MD,** was re-elected secretary. **John W. Barnaby, MD,** re-elected treasurer, was presented a citation for his "devoted and exemplary" service to the hospital.

Four new members added to the executive committee are **William H. Mosberg, Jr., MD, L. Kemper Owens, MD, Edward S. Klohr, Jr., MD,** and **Frank P. Dwyer, Jr., MD.**

* * *

Carl Behm, associate administrator of South Baltimore General Hospital since 1962, has been appointed director of administration, succeeding **Donald T. Mills,** who retired recently.

Associated with the hospital since 1947, Mr. Behm has been principally responsible for the coordination of planning for the recently opened hospital building.

* * *

The Baltimore Area Council on Alcoholism has announced that its information and referral services, conducted up to now in Baltimore city only, will be open to county residents during this year.

". . . in this way, the public as well as the sufferers from this disease can be educated and treated," according to **Harry F. Klincfelter, MD,** vice president of the council.

* * *

Irene Hitchman, MD, Baltimore, has been named Deputy Commissioner of the Maryland Department of Mental Hygiene.

In 1941, Dr. Hitchman joined the staff of Springfield State Hospital, where she was staff psychiatrist and then clinical director. In 1962 she became director of hospital inspection and licensing for the state.

* * *

D. M. Ivey, MD, who has been a resident in ophthalmology in the Mayo Graduate School of Medicine, University of Minnesota at Rochester, has relocated at Andrews Air Force Base.

* * *

Marylanders named to various AMA Committees, Councils, etc. include **John J. Curry, MD,** of Silver Spring, reappointed to the Council on Drugs; **Albert I. Mendeloff, MD,** Baltimore, reappointed to the Drug Utilization Panel on Gastroenterology; **Robert A. Bier, MD,** Washington, reappointed consultant to the Council on National Security; **Abraham J. Mirkin, MD,** Cumberland, reappointed to the Committee on Medical Aspects of Automotive Safety; **Harry M. Robinson, Jr., MD,** reappointed to the Subcommittee on Skin, Committee on Rating of Mental and Physical Impairments.

Others reappointed are **Edmond J. McDonnell, MD,** Baltimore, alternate representative on the Interspecialty Committee from the American Academy of Orthopedic Surgeons; **William J. Peeples, MD,** Baltimore, alternate representative on the Interspecialty Committee, American Association of Public Health Physicians; and **Russell S. Fisher, MD,** Baltimore, Liaison Committee with the American Bar Association.

* * *

Andre Fesus, MD, and **Celeste Woodward, MD,** have just returned from 60-day tours of duty with the AMA Volunteer Physicians in Viet Nam.

* * *

Two NIH scientists have won the Prix André-Lichtwitz, a newly established French award for biological research in the area of phosphorus-calcium metabolism. **Gerald D. Aurbach, MD,** Chief of the Mineral Metabolism Section of the Metabolic Diseases Branch of the National Institute of Arthritis and Metabolic Diseases and **John T. Potts, MD,** former Chief of the Section on Polypeptide Hormones of the Molecular Disease Branch of the National Heart Institute shared the $1,000 award.

The prize is awarded to a scientist or a team of researchers for outstanding studies on calcium and phosphorus metabolism, either in the field of clinical or experimental biology or in the field of basic science. Drs. Aurbach and Potts are the first recipients of the award created under the auspices of the French National Institute for Health and Medical Research.

The two investigators have been in close collaboration on

problems of parathyroid physiology since 1962 at NIH. Since last August, Dr. Potts has been head of the Endocrine Unit at the Massachusetts General Hospital and Assistant Professor of Medicine at Harvard University.

* * *

Two key staff appointments were recently announced by **Stanley F. Yolles, MD,** director of the National Institute of Mental Health, in a move to emphasize Institute grants programs in the behavioral sciences.

Eli A. Rubinstein, PhD, is in the newly created post of Assistant Director of Extramural Programs and Behavioral Sciences, and **Raymond J. Balester, PhD,** is Dr. Rubinstein's Deputy.

Dr. Yolles said the new appointees, both of whom have been with NIMH for several years, will have dual responsibilities in coordinating extramural grants programs and stimulating new developments in the behavioral sciences as NIMH strengthens its research, training and service activities in the field of human behavior.

* * *

Homer L. Twigg, Jr., MD, of Bethesda, has been appointed chairman of the Department of Radiology in the Georgetown University School of Medicine.

Dr. Twigg was awarded his medical degree from the University of Maryland School of Medicine in 1951 and served his residency training in radiology at hospitals in New Orleans and Baltimore.

* * *

The new coronary care unit on Osler 6 of The Johns Hopkins Hospital started into service in November.

The special intensive care unit houses four beds and makes available a concentration of equipment and personnel for the best possible care of patients with acute myocardial infarction. In addition to the improvement in care of emergency coronary patients, the pilot unit will provide a valuable training experience for house staff, nursing staff and medical students.

Gottlieb Friesinger, MD, is medical director of the new unit. **Morrison Hodges, MD,** is assistant director.

* * *

Aris T. Allen, MD, Annapolis, has been selected to serve as minority Whip in the House of Delegates.

Elected by a 25-member Republican caucus at the opening of this year's session of the General Assembly, Dr. Allen is one of 11 negroes in the 185-member House.

* * *

David Rojas Morales, MD, of Baltimore, has been named a Diplomate of American Board of Obstetrics and Gynecology.

* * *

The newly formed Society for Adolescent Medicine, headquartered in Los Angeles, California, has added the name of **Louis J. Pratt, Jr., MD,** a Baltimore pediatrician, to its list of 200 charter members.

The Society has planned a two-day meeting in Washington the first week in March. The sponsors are Childrens Hospital of D.C. and Georgetown University School of Medicine.

* * *

The Committee on Basic and Clinical Research of the National Society for the Prevention of Blindness is accepting applications for grants for scientific study which will contribute to the basic understanding of eye function and pathology and improve methods of diagnosis, treatment and the prevention of blinding eye diseases.

Grants not exceeding $5,000 will be made for a one-year period for projects not being financed by other sources. Renewals may be applied for at the end of the year.

Deadline for applications is March 1, 1969. Application forms may be obtained by writing to the NSPB, 79 Madison Ave., New York, N.Y. 10016.

* * *

Maryland physicians recently named as Fellows-Elect to the American College of Obstetrics and Gynecology include: **Robert M. Barnett, MD,** Baltimore, and **John Edward Jeffrey, MD,** Beltsville.

Junior Fellows-Elect from the State are: **James Edward Anderson, MD,** Silver Spring; **Fritz Apollon, MD,** Baltimore; **George E. Engelke, MD,** Severna Park; **Pablito S. Luz, MD,** Rockville; **John J. Schruefer, MD,** Baltimore, and **Hong Chul Yoon, MD,** also of Baltimore.

* * *

Gerald Gelford, MD, has recently been appointed Radiologist at The Johns Hopkins Hospital and Instructor in Radiology, part time, at The Johns Hopkins University School of Medicine, Baltimore.

Editorial

The year 1966 stands as a memorable milestone with respect to Traffic Safety on the highways of Maryland. That was the year the Federal Highway Safety Act was passed; and the Medical and Chirurgical Faculty sponsored a state-wide Seminar on the Medical Aspects of Traffic Safety. At this meeting, J. Millard Tawes, then Governor of Maryland, commented,

> "As I have said so many times, highway safety is a joint responsibility of government and of citizens, acting either as individuals or collectively, as is the case with this group. Government should provide the leadership, but it cannot do the task alone."

The three principal gubernatorial candidates spoke at the luncheon meeting, the midpoint of the all-day seminar. None were willing to commit themselves to promotion of the so-called "Implied Consent" legislation, despite the compelling figures presented by the first speaker of the seminar.

TOO MUCH

Russell S. Fisher, MD, Chief Medical Examiner of Maryland, indicated that a total of 54%, more than half of all the drivers killed on highways in Maryland during 1965, had a blood-alcohol level in excess of .10%—at this figure it is presumed a person is intoxicated.

But other aspects of traffic safety were discussed that day as well. The drug-oriented society in which we live today was investigated in detail by John C. Krantz, PhD, former Professor of Pharmacology at the University of Maryland School of Medicine. He ably explained that the psychometric drugs—tranquilizers, alcohol—slow the reflex action time of an individual. He warned physicians that people should take and physicians should prescribe drugs that affect the central nervous system *only* when they are definitely indicated. And, more importantly, he strongly emphasized the necessity of warning the patient against the possibility of the drug adversely affecting the central nervous system, especially when operating a motor vehicle.

Abraham J. Mirkin, MD, of Cumberland, Chairman of the American Medical Association's Committee on Traffic Safety, also spoke at this session. His subject covered the medical conditions that could and do affect the driving ability of individuals. While the effect on drivers having such condition would vary with the individual, he stressed the importance of an evaluation being conducted by experts in the field involved. Maryland has a Medical Advisory Board to the Department of Motor Vehicles and evaluations are conducted when instances of physical conditions contributing to hazardous driving are evident. However, at best, it is a somewhat hit or miss program, post *ipso facto,* as compared to an evaluation that would take place *before* the incident or accident occurs.

TOO LATE

Not much has been done since 1966 to effect the changes recommended by this seminar. One accomplishment, however, has been an increase in the visual acuity requirements for drivers; a small item compared to the complete package of recommendations.

However, the 1969 General Assembly, now in session, will have under consideration a complete revision of the Motor Vehicle Code. Included in this revision will be ● the provision of implied consent, as well as provision for license revocation for persons convicted of offenses involving drunken driving; ● a suggestion that there be regular inspection of motor vehicles; ● a provision for driving under the influence of drugs . . . "an habitual user of . . . a drug to (such) a degree which renders him incapable of safely driving a motor vehicle"; and ● provision for driver re-examination on a regular basis.

In addition to the proposed revision of the entire Code, there will be, no doubt, individual bills designed to improve the traffic safety record in Maryland. A bill for the licensure of ambulances is under discussion, as are other provisions necessary for Maryland to receive Federal funds under the Federal Highway Safety Act.

All in all, this is an impressive package, but it is such because the State Legislature has failed in previous years to do what is necessary in the legislative field insofar as the Medical Aspects of Traffic Safety are concerned.

JOHN SARGEANT
Executive Secretary

Ten Commandments For Safer Driving

by Bill Johnston

I Thou shalt heed the stop sign.

The octagon tablet that calleth on thee to pause—and the lamp that turneth to red—hath real meaning to the wise; but they do make a temptation to the fool and the gambler. But to wager thy years against a moment truly giveth thee the appearance of an idiot who knoweth not the odds. The lamp of amber doth call upon thee for caution; and heedest thou it not, the charm of luck shalt depart from thee and thy days in traction shalt be long and miserable.

II Thou shalt not exceed the limits of speed.

Though the horses under thy foot be many, suffer them not to lead thee to thy destruction. Even though the Angel of Death rideth not on thy shoulder; the Eye of Radar doth spot thee from afar, and his master shalt carry thee before the judge.

III Thou shalt not pass when the way is not clear.

Thy life is surely thine own, if ye must cast it away, but thy wayfaring brother and the dependents that are his have no defense when thy juggernaut doth roar upon him in the left lane. They perish in the ruins; and thy ignorance shalt not wash from thy hand the blood of these innocent persons.

IV Thou shalt show courtesy unto others.

A journey unto the temple on a Sabbath hath small meaning if the screeching wheels of thy chariot doth make thy brethren cry out against thee. Thy blaring trumpet causeth not the objects in thy path to crumble; but verily, love doth depart from those who must leap unto safety, and they shalt call maledictions upon thy head.

V Thou shalt not follow too closely.

Tailgating shalt not only put knots upon thy brow; it surely turneth thy grille work into junk. It causeth thy insurance to zoom, and the Patrol to looketh upon thee with disfavor.

VI Thou shalt stay in thy proper lane.

The lanes that are marked for thy journey upon the highway are not for thy pleasure, but for thy safety. Weaving is the trade of the cloth maker; it is not that of the charioteer. It sendeth thy roadmates into ditch or pasture; and they loveth thee not. The blood of thy brother is precious unto him; spill it not with thy careless lane weaving.

VII Thou shalt dim thy lamps when needed.

The lamps of thy chariot are of many candles. Shouldeth thou blind the eyes of thy roadmates, they shalt charge thee with the fury of an herd of elephants; for though they have eyes, they seeth not. And verily, the bones of thee and thy adversary are hard for the gathering in the darkness.

VIII Thou shalt not drive unto exhaustion.

Thou shalt rest when thou are needful of it. Let not thy weary orbs deceive thee, nor pep pills be a prop unto thy tired brain; for they leadeth thee into eternity. And sleepeth thou at the wheel, thy earthly moments shalt be fewer than the mourners at thy tomb.

IX Thou shalt keep thy heap in good condition.

Thy chariot runneth not without attention. The counsel of him who careth for thy crate, if he be worthy, is good; for he is mindful of its needs. Thy life, mayhap, could be in the skilled hands that are his; and truly he hath the power to make thy journey carefree.

X Thou shalt not drive while partaking of drink.

The fruit of the vine may refresh thee after the completion of thy journey, but touch it not while wheeling unto thy destination. It maketh thee a man of distinction only to thine own self; and it aideth greatly in making a widow of thy helpmate. It shalt cause thee to lie in dark dungeons; and thine innocent victims shalt moan, and shalt die, upon the roadside.

Maryland Law

And The Drinking Driver

RUDIGER BREITENECKER, MD

Associate Pathologist, Greater Baltimore Medical Center
Associate Medical Examiner, State of Maryland

In 1968, 860 persons were killed on Maryland streets and highways. As in previous years, nearly 50% were drivers of which about half were under the influence of a significant amount of alcohol. No estimate of alcohol levels is available in drivers not killed in accidents because almost 50% refused to take the Breathalyzer test. Undoubtedly a large number of such motor vehicle operators were under the influence of alcohol, as evidenced by State Police Statistics:

> **Of 460 Breathalyzer tests given in 1968, 439, or 95%, had alcohol levels exceeding 0.10%. This is the level considered by the National Committee on Uniform Traffic Laws to be presumptive evidence that the driver is under the influence of alcohol.**

Maryland and several other states still adhere to the more liberal and more dangerous legal limit of 0.15% blood alcohol, while 14 states (Florida, Georgia, Illinois, Kansas, Maine, Michigan, Minnesota, New Mexico, North Carolina, North Dakota, Pennsylvania, Rhode Island, Vermont, Washington) have conformed to national and international recommendations by lowering the legal level to 0.10%. Utah has lowered its upper limit to 0.08% and New York has an 0.05% limit for drivers under 21.

In an effort to combat the escalating highway slaughter and to save many innocent victims by removing irresponsible drivers from the highways before they can kill or maim through their negligence, the following 30 states have passed an "Implied Consent Law": California, Colorado, Connecticut, Florida, Georgia, Hawaii, Idaho, Iowa, Kansas, Kentucky, Massachusetts, Michigan, Minnesota, Missouri, Nebraska, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Dakota, Utah, Vermont, Virginia, Washington and West Virginia.

An "Implied Consent Law" provides that any person operating a motor vehicle shall be deemed to have given consent to a test to determine the presence and amount of alcohol in his blood if arrested for an offense involving the operation of a motor vehicle. In effect it gives the accused the choice of submitting to a breath or blood alcohol test or to a hearing before the Commissioner of Motor Vehicles to determine whether or not he should lose his license. The scope of such a hearing will cover the issues of whether an arresting officer had reasonable grounds to believe the driver had been under the influence of alcohol, whether he was legally arrested and advised of the penalties for refusing to take the test and whether he refused to submit to the test requested. It does not abrogate the individual's right for his day in court, where the question of whether the driver actually operated under the influence of alcohol would be decided after consideration of all the circumstances and available evidence. The states with this law have accepted the rulings of many different courts including the U.S. Supreme Court that a law of this nature does not violate any of the constitutional guarantees.

The effectiveness of such laws in curbing traffic accidents has been demonstrated in various states and in European countries, such as Austria and Great Britain, which have adopted 0.08% as the legal limit.

Since the introduction of the Breathalyzer test in 1967, late night traffic accidents in London have fallen 41%, deaths by 33% and serious injuries by 22%, when compared to the same period before the advent of breath alcohol testing.

It is generally recognized that the chance of being involved in an accident with a blood alcohol level of 0.05% to 0.10% is 150% higher than when sober. From 0.10% to 0.15% the risk is 250% greater and above 0.15% the chance is 1,000% better. The main reasons are that any drinking of liquor increases reaction time, impairs visual and perceptive ability, decreases comprehension and affects the psychological phenomena of risk-taking, attitude and judgment.

The fact that under the present laws in Maryland the test can be refused without penalty lessens the certainty of detection and consequently lessens the deterrent value of the alcohol test program. Since driving skill cannot be measured conveniently under ordinary circumstances, the measurement of the alcohol level is the only objective criterion for determining whether a driver's ability has been sufficiently impaired to be unsafe. Without such physical evidence courts are seriously hampered in administering justice in a large percentage of "drunk driving" cases.

For these reasons the Medical and Chirurgical Faculty supports an "Implied Consent Law" and the lowering of the blood alcohol limit to 0.10% following recommendations of the American Medical Association, the National Safety Council and other organizations including the American Trial Lawyers Association and following the lead of the numerous states listed above.

Confusion often exists as to the necessary curtailment of social drinking in order to stay below an 0.10% blood alcohol level. The limitation is not as great as one might imagine. For example, an average person must drink at least 3 to 4 ounces of liquor or 3 to 4 bottles of beer in one hour to reach a 0.10% alcohol level. To reach a blood alcohol percentage of 0.15% he must have consumed about 6 one-ounce drinks of 100 proof liquor in one hour. This would be heavy drinking for the average social drinker. The consumption necessary to reach these levels increases with body weight and with the span of drinking time.

In addition to the promotion of highway safety, physicians also are interested in another less commonly recognized benefit of alcohol testing. Such a test may be essential to distinguish symptoms due to injury or illness from those due to alcohol intoxication. If the symptoms commonly associated with alcoholic influence are observed, a negative breath or blood test would suggest a medical emergency. In these instances prompt medical attention rather than incarceration is essential and may be a life-saving measure.

The problem of the driver under the influence of alcohol demands vigorous action. The enactment of an "Implied Consent Law" and the lowering of the legal alcohol limit would provide a significant improvement in traffic safety and would put Maryland on a par with the progressive states and nations. Such measures deserve the wholehearted support of all citizens concerned with traffic safety. Physicians can help the passage of these bills, which again will be introduced in the next legislative session, by expressing their support to their state senators and delegates.



"Implied" Consent—

Of all the thousands of legal cases pending in the state, approximately 85% are concerned with motor vehicle accidents, and the damages and injuries that have occurred as a result of them.

The following article is an excerpt from a presentation on the Legal Problems Involved in the Development of Legislation by J. Dudley Digges, Chief Judge, Seventh Judicial Circuit, State of Maryland, presented October 12, 1966 at the Seminar on the Medical Aspects of Traffic Safety, sponsored by the Faculty and the Maryland Chapter of the American College of Surgeons.

Judge Digges proposes that legislation, in whatever form, should relieve the courts of trying many of the motor vehicle cases, and place the responsibility for the mishandling of a motor vehicle on the driver himself, with the medical profession and the Commissioner of the Department of Motor Vehicles setting the necessary standards for reinforcing this sense of responsibility.

And What It Implies

"It is important that we do everything both in and out of the medical field, both in and out of the legal field, and indeed both in and out of all fields, to attempt to solve this problem, which is becoming such a menace all over America that it would not surprise me if someone suggested the only answer to it was to outlaw the automobile itself." These were the sentiments presented by J. Dudley Digges, Chief Judge (Seventh Judicial Circuit) during the Seminar on the Medical Aspects of Traffic Safety.

To date, the automobile has not been outlawed—we doubt if it ever will be—and we are no closer to a solution than we were three years ago, the main problem being that whatever solution is attempted must fall within the framework of constitutional privileges. This framework, in turn, is dependent upon certain developments, in this case, a certain "unanimity among physicians" to the point where a law can be based on sound principles.

According to Judge Digges:

The number one requirement here is that the statistics you gather, which show, for example, that a certain percentage of alcohol in the blood destroys the effectiveness of a driver, be a reasonable basis for a decision. This can be determined only by you in the medical field and by those associated with you.

From a legal point of view the problem goes back to the concept that the driving of a motor vehicle is a privilege and not a right.* Just how long that concept will continue in effect I do not know, but when it changes, and it is determined that driving is a right rather than a privilege, then all of the decisions of the law that have been made or suggested will go down the drain along with the present concept.

A change may come as we in this country become more and more dependent upon the automobile for our livelihoods. . . . It may be that one of these days it can be so wound up in our daily lives that the operation of a motor vehicle will be deemed a right, guaranteed by the various provisions of the constitution, and not a privilege.

* The concept of driving a car as a privilege was adopted by the National Conference of Commissioners on Uniform State Laws in 1957, and approved by the American Bar Association in the same year.

Meanwhile, in today's law we deal with this as a privilege, a privilege which is granted to an individual, but which may be withdrawn, provided of course that the reason for withdrawal meets other constitutional tests, and provided that all in the same category are treated alike.

It is within this framework that some of the proposed laws are referred to as the "implied consent" laws.

The law provides that anyone who applies for an operator's permit and who uses that permit to operate on the highways of the state, impliedly consents to a test to determine whether or not he was driving under the influence of alcohol and to the withdrawing of blood, providing it is done by a doctor, a qualified technician, chemist, registered nurse or someone in an allied field.

The law then specifies—and this must be based on medical conclusion, with reasonable unanimity among your profession—what degree of alcohol, in what category. Of course the law would have to be changed if you made discoveries which changed your conclusions.

There are many other laws that could be considered. For example, there could be a law based not on *implied* consent, but on *affirmed* (express) consent and requiring the individual to sign the consent in order to get a license. That has its drawbacks, however, because out-of-state drivers in a state with such a law may not be subject to it in their home states and implied consent would be applicable to them.

One case that seems to have a great bearing on this problem was one decided in June, 1966.

The case was one that arose in California (Schmerber vs State of California). The defendant was initially convicted in the Los Angeles Municipal Court for driving a motor vehicle while under the influence of intoxicating liquor. After the defendant's arrest, while he was in a hospital receiving treatment for the injuries suffered in the automobile accident, a blood sample was withdrawn by a physician at the direction of the police officer, acting without a search warrant, despite the defendant's refusal on the advice of his counsel, who was present, to consent to the blood test.

The report of the chemical analysis of the test, indicating intoxication, was admitted in evidence at the trial over the defendant's objection that the compulsory blood test, and the admission of the evidence thereof, violated his right to due process of law under the Fourteenth Amendment, and his privilege against self-incrimination under the Fifth Amendment, his right to counsel under the Sixth Amendment, and his right against unreasonable searches and seizures under the Fourth Amendment, insofar as such rights were secured against the states by the Fourteenth Amendment. So the whole gamut of constitutional objections was raised in this case.

Amazingly enough, the Supreme Court *upheld* the decisions of the California courts five to four. I say "amazingly enough" because the tendency had been five to four the other way up until this case.

The justices decided that the defendant was not deprived of due process of law because the withdrawal was made by a physician in a simple, *medically acceptable* manner in a hospital environment.

The contention, under the Fifth Amendment which guarantees any defendant the privilege against self-incrimination, that this defendant in "submitting" to the taking of his blood was required to give evidence against himself (which, of course, was made unlawful long ago when the Magna Carta was extracted from King John of England) was denied by the Court:

"It could not be denied that in requiring petitioner to submit to the withdrawal and chemical analysis of his blood, the state compelled him to submit to an attempt to discover evidence that might be used to prosecute him for a criminal offense. He submitted only after the police officer rejected his objection and directed the physician to proceed.

"The officer's direction to the physician to administer the test over petitioner's objection constituted compulsion for the purposes of privilege. The critical question, then, is whether petitioner was thus compelled 'to be a witness against himself'.

"History and a long line of authorities in lower courts have consistently limited its protection to situations in which the state seeks to submerge those values for obtaining the evidence against an accused through 'the cruel, simple expedient of compelling it from his own mouth'." Implicit, no doubt, was that this would apply to all things. The Court laid stress on the fact that the drawing

of a little blood was of a very minor nature and akin to compelling a man to submit to a fingerprint test.

"In the present case, however, no such problem of application is presented. Not even a shadow of testimonial compulsion upon, or enforced communication by, the accused was involved either in the extraction or in the chemical analysis. Petitioner's testimonial capacities were in no way implicated; indeed, his participation, except as a donor, was irrelevant to the results of the test, which depend on chemical analysis and on that alone."

The question of whether or not the defendant was denied right to counsel was answered by the Court in saying you cannot argue that he was deprived of counsel just because counsel was not permitted to have him do what he wanted to do and if a lawyer advised him not to submit to the test, he was erroneously advised.

As for the search and seizure problem: "The interests in human dignity and privacy which the Fourth Amendment protects forbid any such intrusions on the mere chance that desired evidence might be obtained. In the absence of a clear indication that in fact such evidence will be found, these fundamental human interests require lay officers to suffer the risk that such evidence may disappear unless there is an immediate search."

But, when there is probable cause to believe that the person may be guilty of the violation of this law, that in itself was justification for the officer requesting the examination over objection, and that if there exists probable cause—smelling of alcohol on the breath, the way the vehicle was being operated, the result of the accident itself—those things in themselves can be taken into account; that if there was probable cause to believe he had too much to drink, that was justification for the arrest, and when there is an arrest, anything that may be found on him and used in this respect is admissible.

It is not merely a question then of dealing with a driver's license. Even in a criminal case (which this was) where the man's liberty might depend upon the result, these constitutional guarantees do not prohibit the taking of blood as it was taken in this case. And, as far as I know, it is the generally accepted way and not peculiar to the case in question.

But it is a serious problem. I am not suggesting that we do not need further legislation. I am suggesting that maybe the time has come to utilize all facilities. The reason is simply this: Fundamental in the American Constitution is the right to trial by a jury. Maybe you would and maybe you would not be amazed at the reluctance of juries to convict people of driving under the influence of liquor.

I admit times have changed, but I remember the first year I was out of law school. I tried before one jury 15 driving-under-the-influence-of-liquor cases and was successful in having 15 of them found not guilty. This was no great feat on my part; juries would not convict anyone. They are reluctant it do it today, because they figure there is a great possibility that "I could be sitting in that defendant's chair."

Therefore I think it is important that we deal with the criminal problem and that we also go one step further and consider the desirability of abolishing most motor vehicle laws as being violations of the criminal laws.

I admit that sounds rather drastic, but let me explain. Among my duties, I sit in juvenile court, and I have young people before me who are charged with all kinds of things—not necessarily motor vehicle charges. I can tell a boy I am going to send him to training school for six months and get no reaction, but as soon as I tell him I will take his driver's license, and give it to the State's Attorney to be returned to the Commissioner of Motor Vehicles, an 18-year-old boy will start to cry.

So I think the way to deal with this problem is to withdraw the individual's privileges when the law has been abused. There should be a simple process to determine that *without* submitting a case to a jury or anyone else.

I realize there have to be certain fundamental safeguards, but we have them now in various boards. The Commissioner of Motor Vehicles passes on the question of whether or not the license is to be withdrawn after a conviction. I do not think it is necessary to impose conviction in the first place. If a motor vehicle operator abuses his privilege for which he is licensed, then his privilege should be withdrawn until he demonstrates a sense of responsibility.


C_2H_5OH

Your Patient's Life—
How Can You Protect It?

S. BAKER
T. BAKER
The Johns Hopkins School of Public Health
Department of Public Health Administration

If your patient is a young adult, in his most productive years, he is more likely to die from an accident than any other cause. If the current trend continues, we can expect about *900 traffic deaths* in Maryland this year. There are two important ways in which you, as a physician, can keep your patients from being numbered among them.

First, advise all of your patients not to drive after having more than two drinks. More than half of all traffic deaths are associated with alcohol.[1, 2] If your patient is an alcoholic, or has a drinking problem, he is especially likely to cause death or injury to himself or others. No other single factor approaches alcohol in importance as a cause of accidents.

Second, urge each of your patients to wear seat belts or diagonal safety straps at all times. The combined three-point belt has been shown to prevent fatal injuries from occurring at speeds of less than 60 miles per hour—whereas unrestrained persons are killed at speeds as low as 12 miles per hour.[3] Seat belts alone are believed to prevent most fatalities and greatly reduce the extent of injuries.

Nationally, the number of motor vehicle fatalities increased by about 40% between 1959 and 1967. As a physician, you are in a strong position to combat this trend, by counseling your patients to take these life-saving precautions.

REFERENCES

1. Fisher, R. S.: The Role of Alcohol in Traffic Fatalities in Maryland, *Maryland State Medical Journal,* January, 1967.
2. Freimuth, H. C., Watts, S. R., Fisher, R. S.: Alcohol and Highway Fatalities, *Journal Forensic Science,* 3:65-71, 1958.
3. Bohlin, N. I.: A Statistical Analysis of 28,000 Accident Cases with Emphasis on Occupant Restraint Value, in *Proceedings of 11th Stapp Car Crash Conference,* October 10-11, 1967, Society of Automotive Engineers, Inc., New York, 1967.

From the Subcommittee on Traffic Safety of the Medical and Chirurgical Faculty of the State of Maryland



The following papers, pages 57-64, were prepared by the Maryland Heart Association for this Journal.

Present Status of Permanent Pacing of the Heart

After almost a decade of experience, the safety and effectiveness of implanted permanent pacemakers has become apparent. Although certain attitudes and methods continue to change, most of the principles of the use of pacemakers are well established.

VICTOR PARSONNET, MD
Director of Surgery
Beth Israel Hospital, Newark, New Jersey
Clinical Associate, Professor of Surgery
New Jersey College of Medicine and Dentistry

Indications

At first, the only indication for insertion of a permanent pacemaker was complete heart block with Stokes-Adams seizures. Today other arrhythmias (Table I) are also treated with permanent implants, because a reliable implantable standby (demand) pacemaker has been developed. This has extended the use of pacers to those conditions where competition between the pacemaker and naturally occurring beats is likely to occur.

TABLE I
Indications for Permanent Pacemaker Implantation

1. Complete atrio-ventricular heart block especially with Stokes-Adams episodes
2. Symptomatic bradycardias
   - Atrial fibrillation with high degree atrio-ventricular block
   - Sinus arrest
   - Digitalis induced bradycardia
   - Intermittent high degree atrio-ventricular heart block
3. Persistent tachycarrhythmias
4. Left axis deviation and right bundle branch block suggestive of bilateral bundle branch block (possible indication)

Patients may survive many years with complete heart block with medical therapy alone, but most of them die suddenly within two to four years, presumably of a Stokes-Adams attack. Moreover, most patients with chronic complete atrio-ventricular heart block, who were "asymptomatic" before pacing, notice improvement in their sense of well-being after pacer implantation, presumably because of enhanced systemic blood flow. Therefore, as a rule, most patients with complete heart block should be paced, whether they have Stokes-Adams or not.

Method

There are two approaches in implanting a pacemaker: transthoracic (or transdiaphragmatic) and transvenous. In one, the electrodes are sewn directly onto the heart muscle, and in the other they are placed in the heart via a suitable vein. We now use the transvenous method exclusively because the operation can be accomplished under local anesthesia and therefore may be performed even in bad risk and aged patients with but minor complications and morbidity, and less than 1% mortality, (Table II).

TABLE II
Mortality Following Pacemaker Implantation

	Complete Operations	Number of Patients	Number of Operative Deaths
Transthoracic (including transdiaphragmatic)	85	74*	2 (2.5%)
Transvenous	199	174**	2 (1.0%)
Totals	284	248***	4 (1.5%)

* Including 1 converted from transvenous and 4 converted from transthoracic to transdiaphragmatic.
** Including 15 converted from transthoracic.
*** 20 patients counted twice.

The pacer implant is done by a team, consisting of a cardiologist trained in heart catheterization, a surgeon, and an electronics technician. Under local anesthesia an electrode catheter is inserted through either cephalic or external jugular veins, and positioned in the apex of the right

ventricle. The threshold for stimulation (excitation threshold) is measured with an external battery powered pulse generator to confirm the satisfactory position of the electrode. (An excitation threshold above 0.9 to 1.0 milliamperes is unacceptable.) The catheter electrode is fixed in place in the vein and the power pack is implanted in a subcutaneous pocket in the upper chest wall. The patient is ambulatory in a day or two and ready for discharge within a week.

Complications with this method occur in 10% of cases. Included in this figure are component and battery failures. Other complications can be avoided or reduced by proper attention to implantation techniques. For example, broken leads can be prevented by proper handling of the electrodes and by placing the pulse generator in the pectoral position where there is little flexing of the wires. Electrode dislodgement can be prevented by fixing the electrode well into the vein, and by positioning it at the very apex of the right ventricle.

A rise in excitation threshold above the output of the pacemaker (exit block) occurs if the electrode becomes separated from the myocardium by scar tissue as a result of poor initial placement, secondary infection, or perforation of the heart. Careful attention to details has almost eliminated these problems.

Preliminary Transvenous Pacing

Although it is tempting to insert a permanent pacemaker as a primary operation, preliminary transvenous pacing is the rule at this institution. A temporary bipolar electrode is inserted through a suitable vein (external jugular, antecubital, femoral or saphenous) into the outflow tract or the apex of the right ventricle. Immediate control of ventricular rate is thereby achieved. Definitive implantation can therefore be done electively, and anesthesia, if needed, can be employed with safety.

Pacing Mode

Three modes of pacemakers are available: fixed rate, P-wave synchronous, and standby. The fixed rate pacer fires at a constant rate which may in some models be altered by external manipulation. The P-wave synchronous pacer rate is determined by the sinus node rate. It is commercially available only for implantation by thoracotomy, not pervenously. The standby or demand pacer fires when the spontaneous rate falls below a preset level. Fixed rate pacing has the advantage of being well tested by time. It is reliable and likely to last three or more years, and therefore is still the method of choice in many clinics.

There is evidence, however, that fixed rate pacing may be dangerous in those patients who have "competition" between spontaneous and paced cardiac complexes. Fatal ventricular fibrillation can occur from stimulation of the heart by the pacemaker when the stimulus falls at the apex of the preceding T-wave. Although at most times the paced human heart may be relatively insensitive to competition, the fibrillation threshold may be lowered by anoxia, digitalis, or electrolyte imbalance. In such situations, competition can produce repetitive rhythms and ventricular fibrillation.

There are now numerous reports of unexplained sudden deaths in paced patients. Eleven sudden deaths have occurred in our series of 228 patients; ten of these patients were paced with fixed rate pacemakers in the presence of competition.

The standby pacemaker fixes effective stimuli only when the spontaneous heart rate falls below preset limits. It thus avoids the dangers of competition and is displacing the fixed rate pacer in many institutions.

Follow Up

Experience with a follow-up clinic has shown that the best way to determine when to change the pacemaker is to analyze the expanded electric impulse (artifact) of the pacemaker. Changes in the pulse rate, and the height, duration, and contour of the artifact, may indicate that pacemaker failure is impending. Seventy-five percent of changes in our clinic have been elective as a result of such an analysis. The use of a computer facilitates this type of study.

Future

Batteries in existing pacemakers last from two to four years, depending upon the model. The longest life of any pacemaker in our series was 47 months. The electrodes and wire leads, on the other hand, last much longer. Therefore, the most important advance in the future will be an improved power source. This may be in the form of a radioisotope generator now under development. There have also been changes in electrode design that may significantly reduce power requirements and thus increase battery life.

Emergency Treatment of Acute Pulmonary Edema

PHILIP SAMET, MD
Section of Cardiology
Department of Internal Medicine
Mount Sinai Hospital of Greater Miami
Miami Beach, Florida

Acute pulmonary edema is a common, dramatic and often catastrophic event in the life history of the cardiac patient. It is primarily an expression of disease of the left side of the heart and is therefore seen in patients with acute myocardial infarction, mitral valve disease especially mitral stenosis, aortic stenosis, aortic regurgitation, severe hypertension, and occasionally in individuals with rapid tachycardias or pulmonary embolism. Rarer types of pulmonary edema include high altitude pulmonary edema, pulmonary edema following drowning or exposure to noxious gases, and that associated with acute renal insufficiency with overhydration. On rare occasions, pulmonary edema has been associated with neurological disease including trauma and intracerebral hemorrhage.

In the previously untreated patient the cornerstones of treatment of acute pulmonary edema are:

1) sedation, usually with morphine
2) improvement of myocardial function by digitalization
3) onset of rapid diuresis with the newer diuretic agents
4) decreasing venous return and right ventricular output
5) removal of precipitating and aggravating factors such as tachy-arrhythmias, paroxysmal hypertension, arterial hypoxemia, metabolic or respiratory acidosis, and increased work of breathing.
6) proper positioning of the patient.

The above therapeutic measures are most often used concurrently rather than consecutively, especially if the pulmonary edema is severe. Formerly, discussion often centered about the concept whether morphine or digitalis was the most important form of therapy in acute pulmonary edema. The development of the newer diuretic agents such as ethacrynic acid and furosemide has added another primary form of treatment for this condition. Generally, all three agents are administered early in the course of therapy for severe pulmonary edema, in addition to placing the patient in the upright position unless shock is present.

Morphine is best injected intravenously over a two to three minute interval in a dose of 8-10 mg. If necessary an additional 5-10 mg may be given one-half hour later. In mild cases the drug may be given subcutaneously or intramuscularly. Morphine therapy alone will often terminate the mild case of pulmonary edema. If respiratory depression results from morphine administration, nalorphine hydrochlorid (Nalline) should be given intravenously in 5 mg doses which may be repeated once or twice at 20-30 minute intervals. Morphine should be avoided in patients with a history of allergic asthma or chronic pulmonary disease, especially if the arterial carbon dioxide tension (pCO_2) exceeds 45-48 mm Hg. Pulmonary edema in patients with cerebrovascular trauma or accidents should also be treated without morphine. Morphine therapy may result in varying degrees of hypotension which may in turn require therapy.

Improvement of myocardial contractility by digitalis is a second foundation of therapy. Intravenous therapy is generally advisable. If the situation is extremely grave and if the physician is

experienced in the use of ouabain, 0.5 mg of this glycoside is given by vein and followed by further doses of 0.1 mg every half hour to a maximum of 0.8-1.0 mg or until clinical improvement is noted. One must be certain that the patient has *not* been receiving digitalis therapy for at least two and preferably three weeks if intravenous digitalis preparations are employed. Much more frequently lanatoside C or digoxin are utilized for rapid intravenous digitalization of patients in pulmonary edema. The time of onset of action of these latter two agents is less than one hour when given intravenously. If digoxin is utilized, 1.0 mg is given intravenously, followed by one or two 0.25 mg doses if needed. Maintenance therapy with oral or intramuscular digoxin may then be employed.

The development of rapidly acting diuretic agents—ethacrynic acid and furosemide—has altered the therapy of acute pulmonary edema. The use of 1-2 ml of a mercurial diuretic intravenously was formerly advocated, but since the onset of a diuresis was delayed for four to six hours, the issue was usually decided before an effective diuresis ensued. However, administration of either ethacrynic acid or furosemide results in much more rapid diuresis. Both agents when given intravenously produce the onset of diuresis within 15-20 minutes. A liter of urine will often be produced within 60-90 minutes. Oral administration produces onset of diuresis within 60-90 minutes. Ethacrynic acid is given in doses of 50-100 mg intravenously in pulmonary edema. Oral therapy (100 mg) is less desirable for therapy of pulmonary edema. Furosemide has not as yet been released for intravenous administration but is available for oral use. Theophylline derivatives such as aminophylline (0.24-0.48 G in 20 ml of solution and given slowly intravenously) are advocated by some clinicians, but this observer has seen little evidence of a beneficial effect unless severe bronchospasm complicates the picture of pulmonary edema. Similarly, surface tension reducing agents such as ethyl alcohol have not been of significant benefit in our hands.

Measures to decrease venous return are employed, especially when the above approaches are not effective or only partially effective. The primary measures in this category include rotating tourniquets and phlebotomy. Phlebotomy is accomplished by removal of 500 ml of blood as rapidly as possible. Positive pressure breathing may also be employed to decrease venous return. Blood pressure must be watched carefully during positive pressure breathing to prevent serious hypotension. Other measures to decrease venous return, such as spinal anesthesia and stellate ganglion blockade, have been suggested to decrease venous return, but have been limited use. Ganglionic blocking and sympatholytic agents such as mecamylamine (1-3 mg diluted in 50 ml of 5% glucose in water and given slowly intravenously), hexamethonium, dibenamine, and dihydroergokryptine have been employed but experience has been limited. The one situation in which these agents may be useful is in the treatment of pulmonary edema in patients with severe systemic hypertension.

The last category of therapeutic measures embodies the removal of precipitating factors. These include the correction of arrhythmias with rapid or slow ventricular rates. Arterial blood gas analysis has become an essential aspect of therapy in patients in pulmonary edema who do not readily respond to treatment. The most common acid-base abnormality detected is respiratory alkalosis which does not require specific therapy. Decreased peripheral perfusion due to low cardiac output is often a cause of metabolic acidosis, which requires correction with intravenous sodium bicarbonate. Occasionally, endotracheal intubation or tracheostomy are required for adequate carbon dioxide exchange. Correction of arterial hypoxemia is accomplished by inhalation of high oxygen mixtures and correction of the pulmonary edema. The role of hyperbaric chambers in correction of arterial oxygen unsaturation remains for future study. Surgical correction of aortic and mitral valve disease may be needed to prevent recurrent pulmonary edema. The final precipitating factors of pulmonary edema that may readily be dealt with involve restriction of activity and prevention of excessive sodium intake.

Utilization of one of the varied types of assisted circulation such as veno-arterial shunting, left heart bypass of counterpulsation offers future promise for the therapy of patients with non-responsive pulmonary edema, but the clinical value and role of these methods have not yet been determined. On the other hand, peritoneal dialysis with hypertonic glucose solution offers a more immediately available palliative procedure for a few selected patients with non-responsive continual pulmonary edema.

Clinical Applications of Inhibition of Beta-Adrenergic Receptors with Propranolol

Propranolol, the first clinically useful beta-adrenergic blocking drug, was recently placed on the market after several years of exhaustive clinical trials. On the basis of many investigations, it appears that blockade of the beta-adrenergic receptors may be useful in the treatment of several types of cardiac problems. However, as with any potent drug, the physician must possess full knowledge of its mechanism of action and possible hazards before prescribing. This article is intended as a brief survey of the actions and uses of propranolol for the practicing physician.

MORRIS STAMPFER, MD
Associate in Medicine
Albert Einstein College of Medicine
Bronx, New York

STEPHEN E. EPSTEIN, MD
Acting Chief, Cardiology Branch,
Chief, Section on Circulatory Physiology
Cardiology Branch, National Heart Institute
Bethesda, Maryland

Pharmacology

The work of Dale, Ahlquist and others has established the existence of different types of responses to adrenergic stimulation, dependent on the presence of either of two types of receptor sites in the tissues. For example, stimulation of alpha-adrenergic receptors causes constriction of blood vessels, while stimulation of beta receptors causes vasodilation. Only beta receptors are located in the heart, and stimulation of these receptors results in an increase in the heart rate and the force of cardiac contraction. The endogenous catecholamines, epinephrine and norepinephrine, stimulate both alpha and beta receptors, while the catecholamine isoproterenol stimulates beta-adrenergic receptor sites exclusively. Although alpha-adrenergic blocking drugs have been known for many years, propranolol is the first generally available drug which antagonizes the action of catecholamines at the beta-adrenergic receptor sites, thus causing slowing of the heart rate and a decrease in the force of cardiac contraction.

Clinical Uses

1. *Angina Pectoris*

Angina pectoris is due to a disproportion between the O_2 requirements of the myocardium and the O_2 supply so that the supply of oxygen is inadequate to meet myocardial metabolic demands. In theory, angina can be relieved either by increasing oxygen delivery or decreasng metabolic requirements. Since both heart rate and the force of contraction are important in determining the amount of O_2 required by the heart, propranolol, by decreasing these parameters during exercise, is often successful in relieving angina that is refractory to the more commonly used drugs. The dose required is highly variable and is best ascertained by starting with a small dose such as 10 or 20 mg by mouth four times daily, and increasing gradually until attacks of angina are substantially reduced in frequency. Doses of 400 mg daily or more have occasionally been used, although the most commonly required dosage ranges from 120 to 240 mg daily. Very close observation of the patient is necessary since congestive failure may appear. Such symptoms may often be controlled with digitalis glycosides and diuretic agents. However, if these interventions are not successful in controlling symptoms of failure, propranolol must be discontinued.

2. *Arrhythmias*

Propranolol can be used in the treatment of various cardiac arrhythmias; its beneficial effects are due not only to beta-adrenergic blockade, but in certain arrhythmias to a quinidine-like action as well.

Propranolol may abolish arrhythmias caused by digitalis intoxication, including frequent premature ventricular contractions and ventricular tachycardia. It should be stressed, however, that there is no evidence that propranolol is superior to some of the other commonly used antiarrhythmic agents.

In arrhythmias not due to digitalis, such as atrial fibrillation or atrial flutter with rapid ventricular response, propranolol usually can be relied upon to slow the ventricular rate. Recurrent attacks of paroxysmal atrial tachycardia may occasionally be reduced in frequency or prevented by propranolol, although sufficient information to assess long-term results is not yet available.

When emergency treatment is required, propranolol should be given intravenously in doses of not more than 0.5 mg every three to four minutes until the desired effect is achieved or signs or symptoms of worsening cardiac decompensation are noted. The drug should not be used in complete atrioventricular block with idioventricular rhythm (unless a cardiac pacemaker is in place) since electrical activity may be slowed further or arrested.

3. *Idiopathic Hypertrophic Subaortic Stenosis*

Propranolol has been found to be beneficial in many patients with idiopathic hypertrophic subaortic stenosis (IHSS). The exercise tolerance of patients, whose primary symptom is angina pectoris, has been improved by propranolol, and the frequency of syncopal episodes and of arrhythmias can be reduced in other patients. The reason for this improvement probably is due to the fact that obstruction to left ventricular outflow in IHSS is made worse by drugs or maneuvers that increase the contractile state of the heart, such as isoproterenol or exercise. Propranolol, by decreasing sympathetic stimulation of the heart, decreases this obstruction. This change is less marked at rest, when there is normally little sympathetic stimulation present, but becomes more significant during exercise.

It should be stressed that in patients with IHSS and congestive failure, the drug may produce deleterious effects just as in patients with other types of heart disease who have signs and symptoms of cardiac failure.

Side Effects and Contraindications

By interfering with sympathetic stimulation to the heart, propranolol decreases the cardiac output response to exercise in normal subjects, and thereby impairs their capacity to perform intense exercise. This finding demonstrates the significant role of the sympathetic system in the cardiac response to the stress of exercise. Propranolol also alters the diurnal pattern of sodium excretion in normal subjects and in patients with mildly impaired cardiac function. However, in patients with severe cardiac decompensation its administration may cause frank retention of sodium and fluid, changes resulting in progressive edema accumulation and symptomatic deterioration. Thus, in patients with heart disease whose cardiac reserve is diminished and who depend upon sympathetic support to maintain compensation, inhibition of cardiac sympathetic stimulation may lead to severe and sometimes irreversible symptoms of cardiac failure.

Other major side effects that have been reported are severe hypoglycemic reactions occurring in patients taking insulin or oral hyperglycemic agents, and acute pulmonary insufficiency due to bronchospasm, a complication that may occur in patients with obstructive airway disease.

Summary

Blockade of the beta-adrenergic receptors is of significant benefit in selected patients with various types of heart disease. Angina pectoris, digitalis-induced arrhythmias, atrial fibrillation and flutter, and idiopathic hypertrophic subaortic stenosis are conditions in which this drug may be useful. However, caution and continued close observation of the patient is always necessary because removal of sympathetic support to the failing heart may result in severe cardiac decompensation. Propranolol and other beta-adrenergic blocking drugs should not be administered to patients with congestive heart failure that does not respond to digitalis glycosides and diuretics, and to patients with atrioventricular block, unless a cardiac pacemaker is in place. In addition, they should be given with extreme caution to patients with obstructive airway disease and to patients taking insulin or oral hypoglycemic agents.

In the evaluation of a patient with valvular or coronary artery disease, the history and physical findings may disclose that a significant functional impairment is present. It is not generally possible from the clinical examination to adequately separate that limitation due to mechanical factors (such as valvular disease) from that due to a concomitant abnormality of the myocardium. The rheumatic process itself, and/or changes secondary to a valvular lesion, may result in such significant changes in the myocardium that the status of the heart muscle becomes the most important factor relative to the patient's operative risk and subsequent morbidity. Myocardial function may also be adversely affected by coronary artery disease increasing the functional limitation in patients with valvular disease. This is of additional importance now that surgical measures for the relief of isolated arteriosclerotic heart disease are available.

The Evaluation of Left Ventricular Myocardial Function in Patients Undergoing Cardiac Surgery

JOSEPH W. LINHART, MD
Chief, Cardiac Catheterization Laboratory
Mount Sinai Hospital of Greater Miami
Miami Beach, Florida

In order to gain information regarding the myocardial status in a given patient, various physiologic and angiographic procedures are performed in exercise and cardiac catheterization laboratories. The presently clinically applicable examinations include: 1) *Measurement of left ventricular end-diastolic pressure (LVEDP) and cardiac index (CI).*

Although a high LVEDP was once considered to indicate left ventricular failure, we now know that the LVEDP may be elevated due to a pressure load (aortic stenosis) or volume load (aortic or mitral regurgitation), and no evidence of left ventricular failure or poor left ventricular function may be present. Similarly, a reduction in CI does not necessarily indicate poor myocardial function in patients with valvular disease. An elevated end-diastolic pressure in patients with coronary artery disease has more significance however, as our studies have invariably demonstrated a decrease in left ventricular function in these patients.

Since measurement of resting intracardiac pressure and cardiac index may provide incomplete

data in some cases, the patient's response to: 2) *Muscular exercise* can be determined.

The relationship between LVEDP, cardiac output, stroke work and volume, and oxygen consumption is determined at rest and during exercise, usually in the supine position on a bicycle-type ergometer. Normally, the cardiac output will increase by more than 500 cc per minute for each 100 cc increase in minute oxygen consumption. Also, the LVEDP will fall or increase by no more than 2 to 3 mmHg while the stroke work and stroke volume rise. A failing or abnormal left ventricle will have a significant rise in LVEDP (more than 3 mmHg), associated with little increase in stroke work and a falling stroke volume.

A common method used in our laboratory to stress the LV is through: 3) *Angiotensin infusion.*

In this test, angiotensin is infused, I.V., in doses of 2 to 4 micrograms per minute to produce increases in arterial pressure (afterload) in systolic increments of 25 to 30 mmHg. The normal LV responds to this stress by large increases in stroke work with only small increases in LVEDP. A poorly functioning LV increases its end-diastolic pressure (EDP) markedly, but the stroke work rises slightly or even decreases. This test has proven to be especially valuable in patients with coronary artery disease where it may provide the only indication of decreased LV function.

Muscle function may also be evaluated, qualitatively by: 4) *Angiography.*

The injection of contrast material into the LV is filmed on 16 or 35 mm film and then evaluated in various ways for chamber size and shape, sequence, uniformity, and magnitude of contractions and for associated abnormalities such as mitral valve insufficiency or ventricular aneurysm. Abnormalities in the contraction pattern indicate a disorder of left ventricular function. We have found an excellent correlation between LV function demonstrated in this manner and the angiotensin stress test when the LV cineangiogram denotes abnormal function. The LV cineangiogram may be entirely normal, however, and an abnormality of function may only be demonstrated by some form of LV stress testing.

It is also important to determine the angiographic integrity of the coronary arteries in the preoperative evaluation of a patient with valvular heart disease. Although a patient with severe coronary artery disease may have normal LV function, more often there is a functional impairment which affects the immediate surgical risk and subsequent long-term results. This is over and above the risk inherent in the valvular surgery itself.

It must be mentioned that although these four routinely used methods are valuable for the determination of left ventricular function, they are only indirect estimates. It is more appropriate to relate the tension or force developed in a muscle to the extent and velocity of muscle shortening. This is only done experimentally, today, and necessitates numerous assumptions in patients. Eventually, however, it will be possible to extend these techniques to routine clinical practice.

Clinical experience has now shown that in otherwise comparable patients those with poor myocardial function have the highest operative risk, stormiest post-operative course, and the poorest post-operative function. Several factors may be important to explain post-operative morbidity to patients undergoing valvular replacement. 1) Significant leakage around the rim of the prosthetic valve. 2) Other residual valve lesions. 3) Prosthetic valve gradients. 4) Coronary artery disease. 5) Poor myocardial function. It is necessary to determine, using the previously mentioned diagnostic tests, which of these factors is important since the first three, and occasionally the fourth, are open to direct surgical attack. Unfortunately, in our experience, most of the poor surgical results have been associated with significantly impaired myocardial function. The patients present with evidence of congestive heart failure and since the mechanical factor (valve lesion) has been relieved, it is easier to obtain evidence of the true state of the myocardium. In some however, severe coronary artery disease is contributing to this malfunction, especially in older patients following aortic valve replacement. When isolated myocardial dysfunction is found, only intensive medical therapy can be offered.

———O———

your medical faculty at work

by John Sargeant
Executive Secretary

A special meeting of the Executive Committee was held December 19 during which the following actions were taken:

1. The following motion was adopted—

   "That the Executive Committee on behalf of the Faculty accept in principle the consideration of Blue Shield and the Physicians of Maryland underwriting the physicians' portion of the Medicaid Program in Maryland providing, following investigation, proper information and figures are brought back to this Committee, and to Council."

2. Authorized certain staff travel for 1969, pending adoption of the 1969 budget.
3. Authorized preparation of a statement to be presented at hearings before the U. S. Department of HEW in Washington, D. C. on December 30, 1968.
4. Authorized dispatch of a letter to the Mayor of Baltimore city urging that the City Health Commissioner be reappointed to that office for an additional term.

———O———

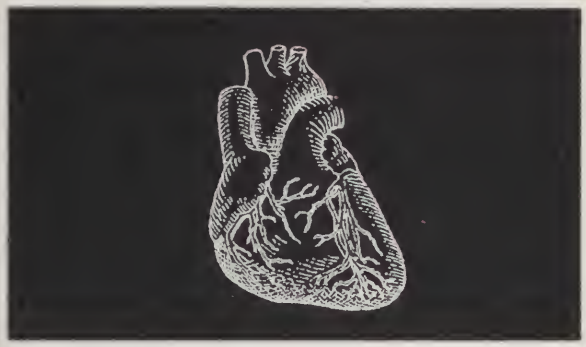
The Executive Committee at its January 9, 1969 meeting took the following actions:

1. Approved "copy" for an educational pamphlet on the Commission on Medical Discipline. This will be distributed to all members when printed.
2. Heard details of the Regional Meeting on Health Care Costs, sponsored by the U. S. Department of HEW in Harrisburg, Pa., and attended by the Faculty president.
3. Designated an "ad hoc" committee to be named by the President to investigate the legality of "consent" forms used by physicians; and the legality of treatment of "emancipated minors".
4. Declined to appeal a court order requiring the Faculty to permit a Judge to inspect records of the Faculty "In Camera".
5. Declined to provide legal defense for a physician not entitled to it because of late payment of dues even though he offered to underwrite the expenses in providing such a service.
6. Disbanded the Special Liaison Committee with the State Health Department and assumed the functions of this group.
7. Approved in principle the Health Resources Manpower Program as proposed by the Hospital Council of Maryland.
8. Approved the Guidelines for Citizens Service Award, as recommended by the Public Relations Committee.
9. Learned that no insurer for Professional Liability would cover a physician for any "punitive damages" award.
10. Referred to the Prince Georges County Medical Society the request from the Prince Georges Health Planning Council for comments on its preliminary study dealing with hospitals in that county.

(Continued next page)

11. Provided a nominee to the State Health Commissioner to be considered for his recommendation as an appointee to the Maryland Occupational Health and Safety Advisory Board.
12. Authorized transferring certain activities now conducted at the Presidential dinner to a House of Delegates session.
13. Designated a Faculty representative to the Administrative Committee of the Regional Medical Programs.
14. Authorized the President and President-Elect to name certain advisory groups in connection with the State Department of Health and Mental Hygiene budgets.
15. Stated it had no objection to a change in hospital licensure regulations which would not require a separate license for outpatient services on separate premises when operated by a hospital.
16. Authorized appointment of a special committee to consider the problem of Drug Abuse and Misuse.
17. Authorized representation and designated two persons to attend a meeting being sponsored by the AMA to discuss the JCAH revised standards for accreditation prior to their publication.
18. Declined to permit use of Osler Hall on the first Thursday of each month by the Baltimore City Medical Society because of other conflicts that evening, but suggested an alternate Thursday for the Society's use of the Hall.
19. Declined to be represented in an official capacity at the First National Conference on Abortion Laws.
20. Determined that no reply was necessary to a telegram from Wilbur J. Cohen, Secretary of the U. S. Department of HEW, which had urged physicians to use restraint on the charging of fees under Medicare, Part B; and requested patients to use restraint in the utilization of the services.
21. Authorized dispatch of a congratulatory letter to the Governor on his election and the offering of Faculty assistance.
22. Declined to underwrite the expenses of a member of the Emotional Health Committee to attend the Chicago National Conference on State Mental Health Representatives.





JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Pulmonary Function Testing in the Office

Formerly, pulmonary function testing was done primarily in larger institutions and was performed by physicians specially trained in pulmonary physiology. In recent years, testing has spread to smaller institutions and, in particular, to the physician's office. This has occurred largely as a result of increased awareness on the part of the physician (and the public) of the frequency of chronic bronchitis and emphysema and because of the commercial availability of relatively inexpensive pulmonary function testing equipment. This increase in the number of testing facilities is of importance because most pulmonary laboratories are set up for "in depth" studies and are not capable of handling a large patient load. Certainly any cigarette smoker who has a chronic productive cough or dyspnea should have the benefit of pulmonary function studies as a part of his evaluation. There is also good reason for periodically assessing ventilatory function in asymptomatic adult cigarette smokers in order to detect obstructive disease early. The physician's office is a logical place for such testing.

RICHARD W. BLIDE, MD
Assistant Professor of Medicine
Head, Pulmonary Laboratory
University of Maryland Hospital
and School of Medicine

With this development, pulmonary function testing and its interpretation have passed into the hands of physicians who have had little or no formal training in this area. This has resulted in problems relating to the use of pulmonary function equipment and the interpretation of results.

Many physicians in practice will at some time consider the advisability of obtaining pulmonary function testing equipment. For those who do not have specialized training in chest disease, it is recommended that the only piece of equipment obtained be a spirometer. Other types of testing require more technical skill and a more sophisticated knowledge of pulmonary physiology. Pulmonary laboratories can provide such studies when these are necessary.

Several spirometers are available and, in general, the quality is in proportion to the cost. One should look for a spirometer that is sturdy in construction, has a low apparatus resistance and is convenient to use. The paper speed should be sufficient to make accurate measurements and it should allow one to see changes in flow characteristics during forced expiration. These characteristics are one means of assessing the validity of the curve, and are masked if the paper speed is too slow.

Spirometry allows one to assess two types of ventilatory insufficiency: restrictive and obstruc-

tive. Restrictive ventilatory insufficiency is due to a loss of ventilable lung tissue. This may occur as a result of inflammation or fibrosis of the lung parenchyma, destruction or resection of lung tissue, heart failure, or chest wall disease (pleural, skeletal, muscular, or neurologic). A restrictive defect also occurs in emphysema and roughly parallels the loss in elastic recoil of the lungs as the destructive process progresses. The vital capacity gives a measure of this type of defect. The vital capacity is measured by having the patient inhale as deeply as possible and then exhale slowly until maximum effort results in no further flow. This value is then compared to that of normal individuals of the same age and height.[1]

Obstructive ventilatory insufficiency occurs when there is an increase in resistance to air flow within the bronchial tree. This may result from asthma, bronchitis or emphysema. It is usually measured in one of two ways. The forced vital capacity (FVC) is obtained as described for vital capacity but with the patient exerting a rapid maximal effort and forceably exhaling to the point of no flow. Although many measurements can be made from this curve, the most commonly used one is the forced expired volume during the first second (FEV1). The recorded value can be compared to predicted values.[1] The FEV1 can also be divided by the observed FVC, yielding the % forced expired volume in 1 second (FEV 1%). The latter value should be greater than 70%, and any lesser figure is indicative of obstructive disease. The maximum voluntary ventilation (MVV) can also be performed. This is obtained by having the patient breathe as vigorously and rapidly as possible for a period of approximately 15 seconds. Measurements from several sections of this tracing, of the volume exhaled, including 3 or more breaths, can then be made and converted to a figure representing volume per minute and compared to predicted values. The advantage of doing both the FEV1 and MVV lies in the fact that there is a good correlation between the two measurements. One can be used to check the validity of the other. The absolute value for the FEV1 $\times$ 40 should equal the MVV (plus or minus 10%). All studies should be repeated at least 3 times or until maximum values check within 5% of each other. Measurements should also be repeated after administration of a bronchodilator if the forced flow curve is abnormal.

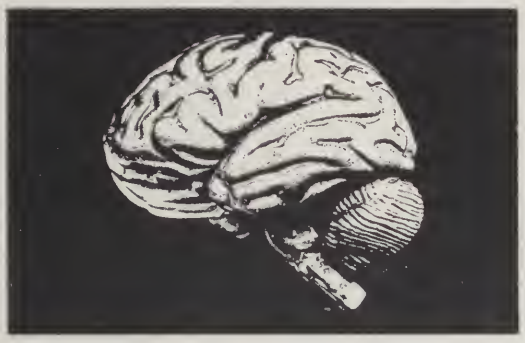
The interpretation of spirometry requires experience and is difficult to discuss briefly. The article by Gaensler and Wright[1] gives a general guideline for the assessment of ventilatory function.

It should be appreciated that spirometry is not an objective test, although absolute numbers are obtained. The test results are influenced by the patient's volitional efforts. If this is not sufficiently great, the values will be submaximal and not indicative of the patient's true ventilatory function. It is important, therefore, to assess the patient's effort during the test, to encourage him to exert maximum effort, and to note when the effort is not adequate. When effort is submaximal, one has to be very careful in diagnosing ventilatory insufficiency rather than a lack of effort. Also, one should not make a diagnosis of ventilatory insufficiency or assess impairment on the basis of spirometry alone, or for that matter, solely on the basis of a battery of pulmonary function studies. The test results should always be correlated with clinical findings. When a discrepancy occurs between the pulmonary function studies and the clinical information, the test results should be questioned and repeated if necessary. As an example, the presence or absence of signs of airway obstruction, as determined by careful chest examination, correlates very well with the results of valid spirometry.

It is thought that the addition of the spirometer to the physician's office is of benefit. Physicians less experienced with this equipment should make every effort to perfect their testing techniques and to validate their test results and interpretations. Patients in whom abnormal spirometric records are obtained might be referred occasionally to a recognized pulmonary laboratory for a repeat study. Comparison of results could then be made and discrepancies resolved through discussion with the laboratory director. While the "under diagnosis" of emphysema and chronic bronchitis has occurred in the past, we are now starting to see the "over diagnosis" of these diseases and particularly the assessment of ventilatory insufficiency at a severer level than actually exists. The limitations as well as the advantages of spirometry should be appreciated.

REFERENCE

1. Gaensler, E. A., Wright, G. W.: Evaluation of Respiratory Impairment. *Arch. Envir. Health,* 12: 146, 1966.



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Voluntary Admissions

The number of patients who were self-admitted to Maryland's psychiatric hospitals reached a record 3,746 (or 33.8% of all admissions) during the 1967 fiscal year. Preliminary data for the twelve-month period ending June 30, 1968 indicate a further increase to 4,347, or 36.2% of that year's 11,997 admissions.

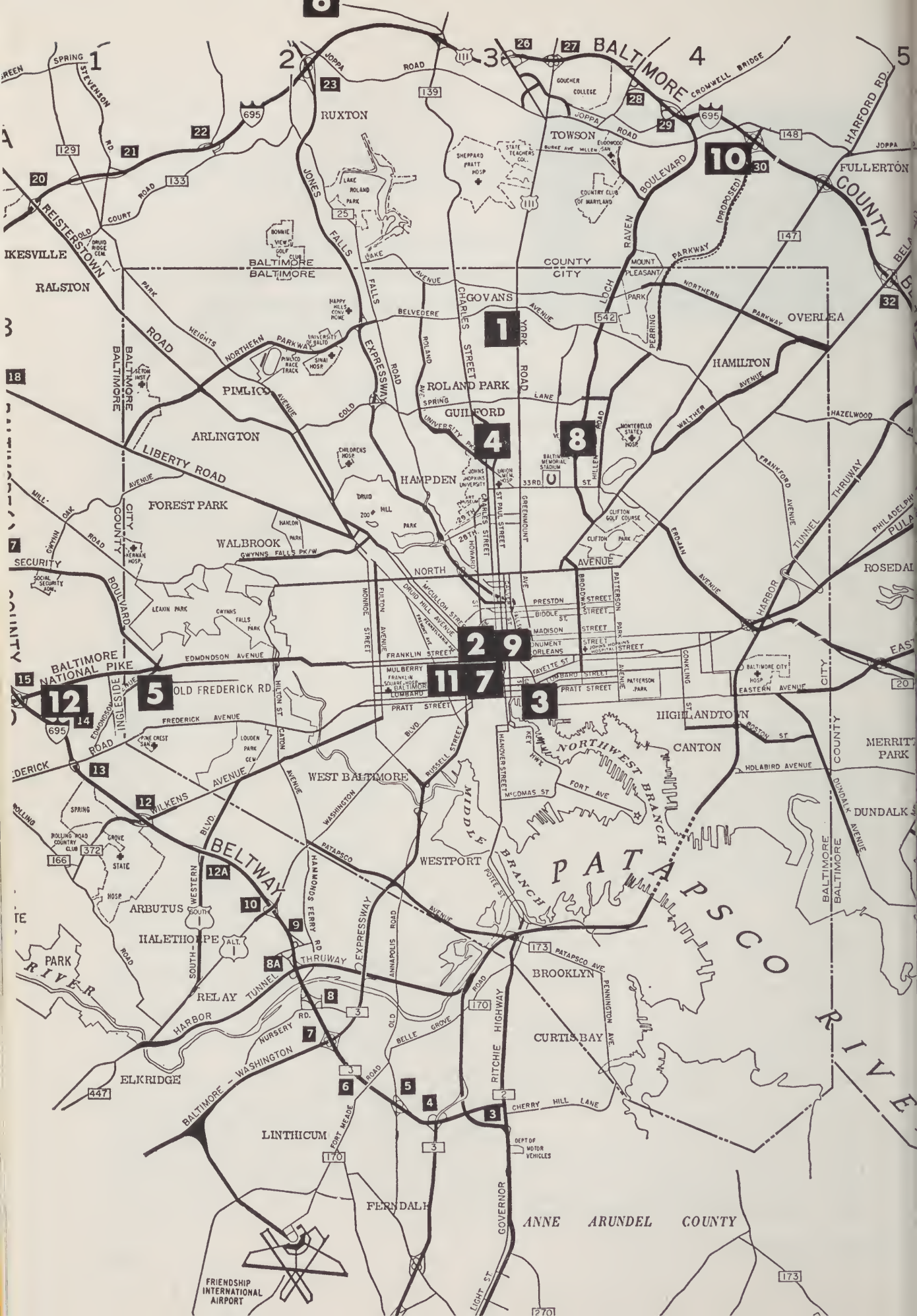
The following table shows that much of this rise is spurious and primarily reflects the rapid growth in admissions for the treatment of alcoholism. As indicated, the number of these patients has nearly tripled in the last five years and they now account for 46.6% of all admissions as compared with 28.7% in 1962. Alcoholics have a higher than average percentage of voluntary admissions. The increasing proportion of total admissions with this diagnosis has therefore produced a concomitant rise in the number and percentage of total voluntary admissions. Within each of the diagnostic categories shown, the proportion of self-admissions remained virtually unchanged between 1962 and 1967.

REPORTED PRIMARY DIAGNOSIS	NUMBER OF ADMISSIONS		PERCENT VOLUNTARY IN EACH DIAGNOSTIC GROUP	
	1967	*1962*	*1967*	*1962*
TOTAL ADMISSIONS	11,091	6,221	33.8	28.1
ALCOHOLISM	5,166	1,785	44.8	44.4
PSYCHONEUROTIC REACTIONS	700	424	52.7	52.8
OTHER PERSONALITY DISORDERS	723	410	23.2	34.4
SCHIZOPHRENIA	2,060	1,738	23.7	19.2
OTHER PSYCHOTIC DISORDERS	449	354	34.7	33.6
DISORDERS RELATED TO OLD AGE	678	730	6.8	5.9
MENTAL RETARDATION	144	157	11.1	10.2
ALL OTHERS	1,171	623	15.9	13.2

A number of other factors are also related to the relative frequency of voluntary admissions. Among these are:

1. PREVIOUS HOSPITALIZATION STATUS—30.5% of admissions with no reported prior psychiatric hospitalization and 36.4% of readmissions were voluntary. Excluding alcoholics, these percentages were reduced to 21.5 and 27.1, respectively.
2. RACE AND SEX—The percentage of voluntary admissions varied from 38.7 for white males to 33.1 for white females, 25.7 for nonwhite males and 26.6 for nonwhite females. This sex difference is mainly related to a seven to one male-female ratio in admissions for alcoholism. The racial variations, however, reflect a continuing greater use of the voluntary admission procedure by white residents.

Many individuals requiring psychiatric hospitalization have sufficient recognition of their illness to voluntarily accept treatment services. Since this initiative is considered to be a potentially positive factor in the treatment outcome, major efforts to encourage use of this procedure are warranted.


BALTIMORE
COUNTY
ANNE ARUNDEL COUNTY
PATAPSCO RIVER
NORTHWEST BRANCH
MIDDLE BRANCH
PATAPSCO
RUXTON
TOWSON
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
ARLINGTON
PIMLICO
RALSTON
OVERLEA
HAMILTON
FULLERTON
FOREST PARK
WALBROOK
SECURITY
NORTH
WEST BALTIMORE
WESTPORT
CANTON
HIGHLANDTOWN
MERRITT PARK
DUNDALK
BROOKLYN
CURTIS BAY
ARBUTUS
HALETHORPE
RELAY
ELKRIDGE
LINTHICUM
FERNDALE
BELTWAY
FRIENDSHIP INTERNATIONAL AIRPORT
CHARLES STREET
YORK ROAD
JOPPA ROAD
LIBERTY ROAD
REISTERSTOWN ROAD
FALLS ROAD
HARFORD ROAD
BALTIMORE NATIONAL PIKE
EDMONDSON AVENUE
FREDERICK ROAD
OLD FREDERICK RD.
HOLABIRD AVENUE
PATAPSCO AVE.
CHERRY HILL LANE
PENNINGTON AVE.
RITCHIE HIGHWAY
GOVERNOR
LIGHT ST.
PATAPSCO AVENUE
DUNDALK AVENUE
BALTIMORE - WASHINGTON
HARBOR TUNNEL THRUWAY
FRANKFORD AVENUE
BALTIMORE CITY
EASTERN AVENUE
PRATT STREET
FAYETTE ST.
BALTIMORE STREET
PRESTON STREET
BIDDLE ST.
MADISON STREET
FRANKLIN STREET
MULBERRY STREET
MONUMENT STREET
PATTERSON PARK AVENUE
GREENMOUNT AVENUE
HOWARD STREET
33RD ST.
29TH ST.
28TH ST.
CLIFTON PARK AVENUE
HILLEN ROAD
WALTHER AVENUE
HAZELWOOD AVENUE
NORTHERN PARKWAY
PERRING PARKWAY
LOCH RAVEN BOULEVARD
(PROPOSED)
COUNTRY CLUB OF MARYLAND
MOUNT PLEASANT PARK
LAKE ROLAND PARK
SHEPPARD PRATT HOSP.
STATE TEACHERS COL.
GOUCHER COLLEGE
CROMWELL BRIDGE
JONES FALLS EXPRESSWAY
CHARLES STREET AVENUE
ROLAND AVE.
BELVEDERE AVENUE
UNIVERSITY PKWY.
GUILFORD AVENUE
SPRING LANE
COLD SPRING LANE
PIMLICO RACE TRACK
SINAI HOSP.
UNIVERSITY OF BALTO.
HAPPY HILLS CONV. HOME
BONNIE VIEW GOLF CLUB
DRUID RIDGE CEM.
LETON HOSP.
CHILDRENS HOSP.
JOHNS HOPKINS UNIVERSITY
UNION MEM. HOSP.
BALTIMORE MEMORIAL STADIUM
MONTEBELLO STATE HOSP.
CLIFTON GOLF COURSE
DRUID HILL PARK
DRUID HILL AVENUE
McCULLOH STREET
MONROE STREET
FULTON AVENUE
HOWARD STREET
CHARLES STREET
ST PAUL STREET
GREENMOUNT AVE.
BROADWAY
PATTERSON PARK
CONKLING ST.
BOSTON ST.
HANOVER STREET
KEY HWY.
RUSSELL STREET
MONROE ST.
CATON AVENUE
WASHINGTON BLVD.
WILKENS AVENUE
FREDERICK AVENUE
EDMONDSON AVENUE
EDMONDSON VILLAGE
INGLESIDE AVE.
SECURITY BOULEVARD
GWYNNS FALLS PK/W
GWYNNS FALLS PARK
LEAKIN PARK
HANLON PARK
KERNAN HOSP.
SOCIAL SECURITY ADM.
PINE CREST SCH.
LOUDEN PARK CEM.
ROLLING ROAD COUNTRY CLUB
SPRING GROVE STATE HOSP.
WESTERN SOUTH-COUNTY
HANNONS FERRY RD.
ANNAPOLIS ROAD
OLD BELLE GROVE ROAD
FORT MEADE
DEPT OF MOTOR VEHICLES
MILL OAK ROAD
COUNTY COURT ROAD
RIVER ROAD
PARK
NURSERY RD.
THRUWAY
TUNNEL
HARBOR
EXPRESSWAY
BOULEVARD
AVENUE
STREET
ROAD
LANE
PARKWAY
HEIGHTS
SPRING
1
2
3
4
5
6
7
8
9
10
11
12
12A
13
14
15
8A
695
83
111
139
147
148
166
170
173
270
372
447
542

Restaurants of Distinction

Locations indicated by numbers on map

The Hecht Co.

ORTHWOOD SHOPPING CENTER
OOFTOP RESTAURANT
Phone 433-8018

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE
Baltimore 1, Md. MU 5-6790

CARRY-OUT SERVICE
SPECIAL LUNCHEON and DINNERS
PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.
Sunday 12 Noon to 3 A.M.

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD
Cocktails Mexican Beers
Tuesday thru Sunday
Open 5:00 P.M.---12:00 P.M.
Dinner and Snacks
Closed Monday
Phone 435-9858

Broadview Restaurant

Cocktails • Dinners • Luncheons
Private Entertaining Facilities
116 W. University Parkway at 39th St.
CALL CH 3-1216

3

THE ORIGINAL
Maria's "300"

33 YEARS SAME LOCATION
Baltimore's Finest Italian Restaurant
THE LEISURE COCKTAIL LOUNGE
5 minutes from Baltimore Civic Center
Open 12 noon to 3 A.M.—Closed Mondays
For Reservations Call 685-2811
2 blocks south of the Flag House
300 ALBEMARLE STREET

7

Miller Bros.

"The Place to Eat"
NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call 752-4822

MILTON INN

Circa 1740

Dine Amid Early American Charm
Warm, Gracious and Inviting

Selected By Life & Time Magazines
as One of America's Finest Inns

Lounge & Dining Room Available
for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.
PARKS 771-4366

10

Club Venus

SPECIAL AT THE
FABULOUS CLUB VENUS
An Evening for Two . . Only $15
Offer good every night except Saturday
Make Reservations Now
Perring Plaza Shopping Center—Beltway Exit 30
For Reservations Call NO 8-2232

9

Cork 'n Bottle Restaurant

STEAK — SEAFOOD — PRIME RIB
COCKTAILS
LUNCHEON — DINNER

Major Credit Cards Honored
Private Party Rooms

22 E. FAYETTE ST. BALTIMORE, MD.
½ Block from Charles Center

539-1268

2

Dobbs House

Breakfast-Luncheon-Dinner
Banquets-Meeting-Private Parties
We Cater Wedding Receptions

Located in Quality Court Motel—West
U.S. Route 40 & Beltway Exit 15
5801 Baltimore National Pike

744-1510

5

Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS
Finest Sea Foods
Prime Meats
5653 Old Frederick Road
East of Ingleside Ave., off Baltimore National Pike
TED KUCHTA, *Manager* Phone 744-0223

11

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*

Your Host
Tom d'Anna

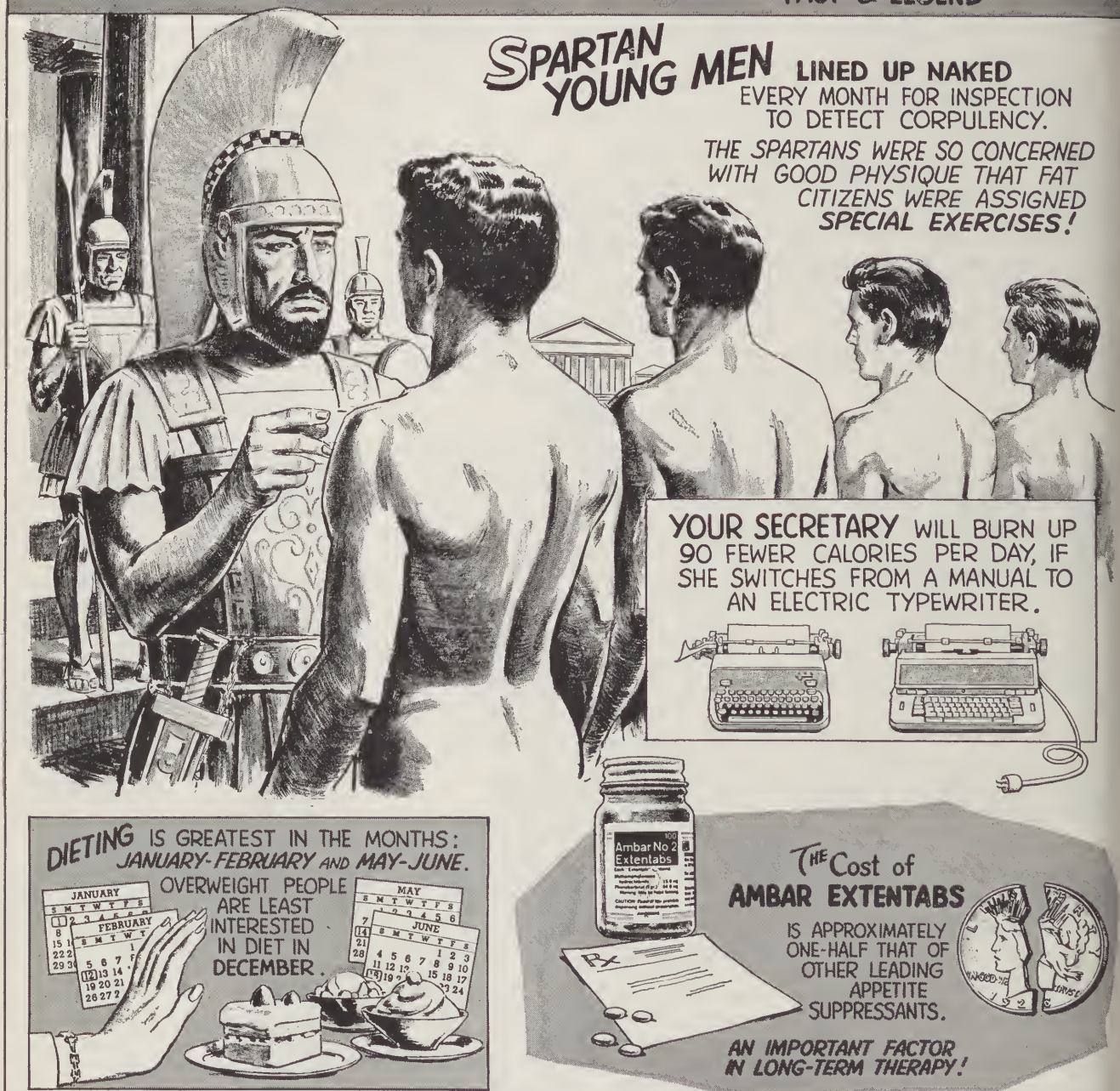
539-9021



The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBINS



"The inconvenience of a cold"

For a cold, NTz® Nasal Spray provides rapid relief of nasal symptoms. Relief starts with the first spray which opens the inferior part of the common meatus. A second spray, a few minutes later, will shrink the turbinates to help provide sinus drainage and ventilation. Dosage may be repeated every three or four hours as needed, for temporary relief of symptoms. NTz is well tolerated but overdosage should be avoided.

As a sinusitis deterrent, NTz Nasal Spray can be used to keep the nasal passages open during a cold to help prevent development of acute sinusitis—or to help prevent the acute condition from becoming chronic.

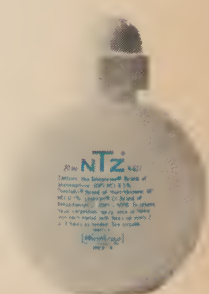
Supplied: NTz Nasal Spray, plastic squeeze bottles of 20 ml.; NTz Nasal Solution, bottles of 30 ml. (1 fl. oz.) with dropper.

NTz is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

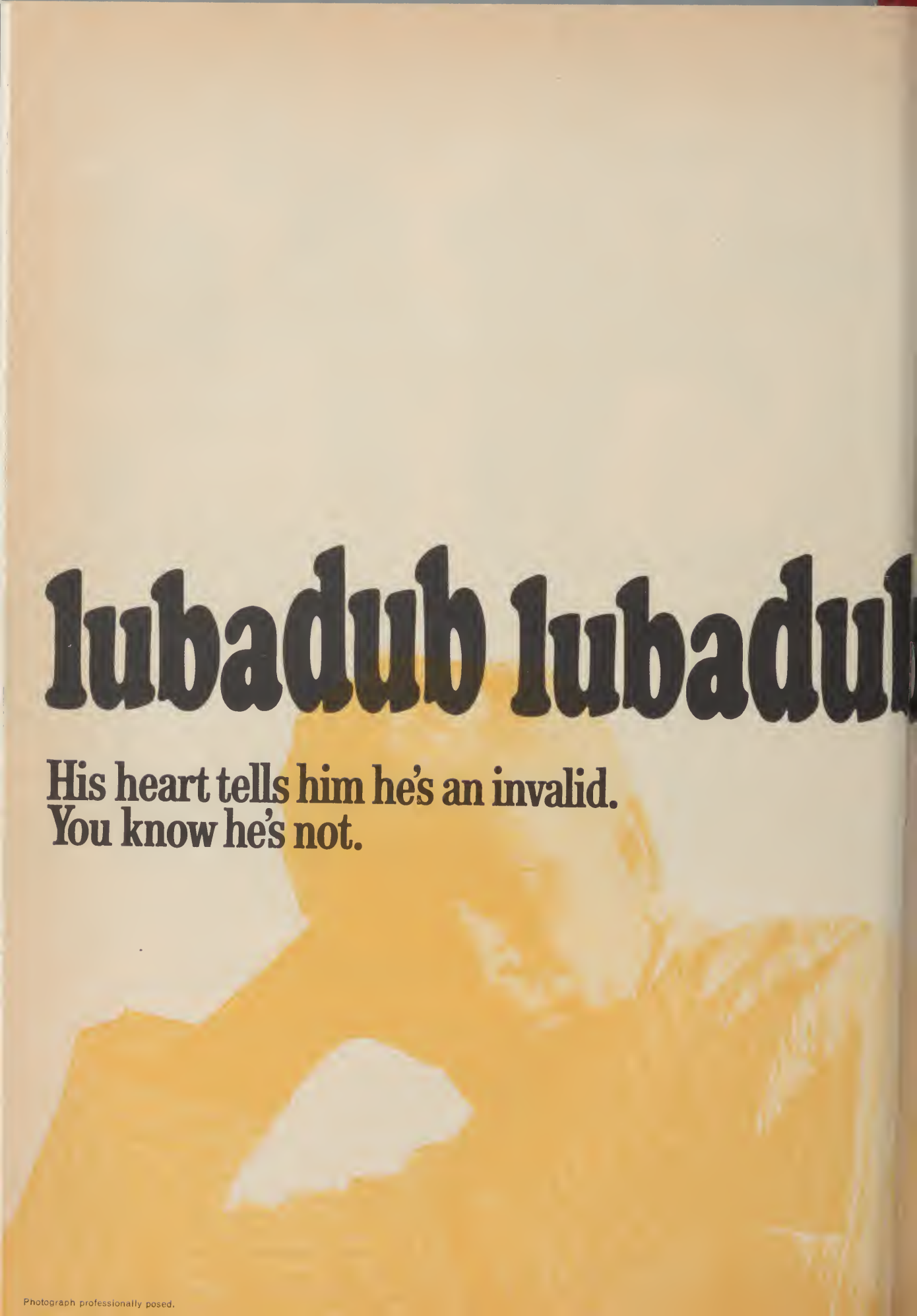
Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

ibadubdub lubadi

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®



The two-stage power of the pink pill for U.R.I. symptoms is nothing to be sneezed at.

The immediate and continuous-release actions built into each Novahistine Singlet can give most of your patients prompt and long-lasting relief from symptoms of upper respiratory infection, including fever, aches and pains. Not only does Novahistine Singlet provide a vasoconstrictor-antihistamine formulation to reduce congestion and help restore normal ciliary activity; it also contains an antipyretic-analgesic compound to relieve the fever, aches and pains that so frequently accompany upper respiratory infections. A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

Pitman-Moore Division of
The Dow Chemical Company,
Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW

John Ruxton
Trust Department
Equitable Trust Bank
Baltimore, Maryland 21203

Please send me more information on HR-10

Name_____

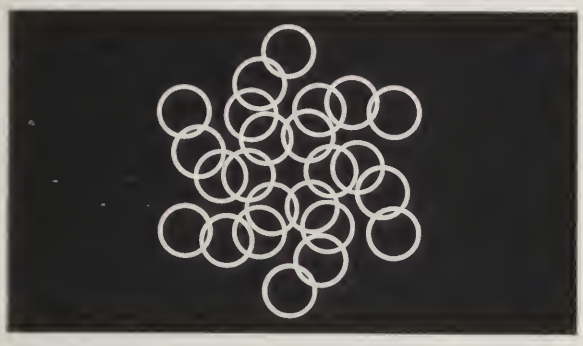
Address_____

City_____ State_____ Zip_____

This coupon can cut your taxes, provide for your retirement, and put more money in your pocket.

The Keogh Act, HR-10, is finally law. And it enables you to set up a retirement plan, cut your taxes, and have more money in your pocket. But it won't do a thing for you unless you act on it. So do it now. Risk a 6¢ stamp. We'll send you a booklet telling you simply, clearly, what the advantages are to you.

Equitable
Trust Bank
Baltimore, Maryland 21203
Member Federal Deposit Insurance Corporation



From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

MEMO

To: The Medical Profession

From: Don P.

Re: A View From the Bottom of the Bottle

As a recovered alcoholic, I spend a lot of time working with other alcoholics and I have heard many stories of their encounters with the medical profession. Except in a few cases, such encounters do not result in the alcoholic's receiving meaningful help. I have frequently encountered the medical profession myself and have gotten no help with my alcoholism.

The medical profession is not alone in its failure to cope with the illness of alcoholism. Society as a whole fails consistently to identify the alcoholic and motivate him toward help. As practicing alcoholics reap the penalties of their uncontrolled drinking, they frequently collide with society. Virtually every collision creates a crisis situation that finds the alcoholic particularly vulnerable to motivation. But, professional "con artists" that we alcoholics are, we generally escape with a warning, a fine, a wave of the finger, a pat on the head, or a prescription, and without the help we need.

Why does society fail to capitalize on opportunities to motivate alcoholics? In the great majority of cases, failure occurs not out of malice, but out of ignorance. Many failures result also from preconceived prejudices toward alcoholics stemming from painful or unfortunate past experiences reaching as far back as childhood.

Many, many people in excellent positions to help alcoholics fail to recognize them or, recognizing them, do not know enough about the illness to provide meaningful help. Law enforcement officers, judges, lawyers, ministers, social and welfare workers, families and, yes, doctors and nurses encounter alcoholics during crisis situations and, more often than not, they fail to recognize or help these sick and desperate people.

Alcoholics consult physicians for a variety of physical and mental complaints which, most often, directly or indirectly, relate to alcoholism. The medical profession is in an excellent position to wave the red flag in the faces of developing alcoholics, but, too frequently, they fail to do so.

I have heard many recovering alcoholics talk of their first encounters with family physicians over the amount of alcoholic beverages consumed. In many cases, the alcoholics were honest, but usually the advice they received was, "Cut it down to one or two a night;" or, "Leave the hard stuff alone—just drink beer;" or a very abrupt, "Stop." Obviously none of these suggestions may be considered treatment of the illness of alcoholism. Even the admonition "Stop," which is what alcoholics must eventually obey, needs to be accompanied by education, therapy and encouragement so that the *need* for alcohol is eliminated.

How often does the average practicing physician encounter alcoholics among his patients? If the incidence rate is 3%, I suggest that at least 5% of the patients a general practitioner treats are alcoholics. Why the higher rate? Because alcoholics are much more susceptible to other illnesses, I assume they make more frequent trips to their family physicians than nonalcoholics. I believe that if a general practitioner sees an average of 200 patients a week, at least ten of them are alcoholics. It would be interesting to know how many alcoholics are diagnosed and, more importantly, how many are appropriately treated.

Many doctors resort to tranquilizers as an aid to alcoholics in stopping or cutting down their consumption of alcohol, a potentially dangerous practice. In many cases, alcoholics, particularly those in the late stage of the illness, will need medication during withdrawal. However, doctors should be aware that they are dealing with individuals with "addictive" personalities. It is terribly easy for alcoholics to become "hung-up" on medications in addition to alcohol. I have met many alcoholics who were also addicted to some sort of medication, and the results can be and frequently are disasterous.

As an example, one 27-year-old alcoholic I have worked with for more than a year has had a very difficult time. He is quite sincere in his effort to recover. Unfortunately, he is an impulsive individual and, on the spur of the moment, he will take that first drink which always leads to a three or four day binge. His last binge took him to a State hospital. The staff there, after careful consideration of his history and physical condition, recommended Antabuse. As soon as he was released, he obediently (and with new hope) went to his family doctor for a prescription for Antabuse. The doctor refused to give him a prescription on the grounds that he would not prescribe any drug that might be harmful. He would, however, put him on tranquilizers. Fortunately, my young friend had beter sense about alcoholism and refused the offer. He is now on Antabuse and progressing nicely.

My own experience with the family physician was interesting. After having been sober for about one year, I told him I was an alcoholic. I also told him that in the event he encountered alcoholics in his practice, I would be happy to talk with them on his referral. My offer angered him and he quickly assured me that alcoholics need *medical* attention. I agreed and dropped the subject. I hate to think this otherwise brilliant young doctor feared that I would somehow cut into his rightful domain if I tried to complement his treatment of alcoholics.

The physicians in the two examples above, I hope you will agree, do not know enough about the illness of alcoholism. To be perfectly fair, we can't hold them, and others like them, entirely responsible. After all, until just the last couple of years medical schools were offering little meaningful education about this illness. A medical friend has told me that if a doctor is over 35, he has probably received no more than one or two hours education on alcoholism, the illness that ranks third on the list of public health problems. I heard another doctor say that his one hour lecture on alcoholism in medical school consisted of detailed instructions on how to get a "drunk" out of the waiting room without disturbing the other patients. Is this the most we can expect from our medical schools and their graduates?

Many doctors will complain about their lack of success in treating alcoholics. The term "poorly motivated" is frequently used in talking about their alcoholic patients. In all too many cases, alcoholics are faced with "poor motivators," but physicians find it easier to blame the poor patients, discharge them and let them drift toward premature death or insanity. Quite frequently the problem with doctors who fall into this category is that they attempt to treat alcoholism and the alcoholic independently, without referring to other kinds of services. They fail to understand the complexities of an illness that often requires a wide variety of professional help.

As noted above, the illness of alcoholism is ranked as the third public health problem. I suspect it should be ranked higher. If the true mortality rate were known it might rise to number one. But again, many well-meaning doctors cloud the issue and "protect" the family by listing on death certificates some secondary condition caused by the alcoholism. I fear they have the still prevalent

attitude that alcoholism is somehow a dirty word. When will the medical profession stop giving only lip service to the AMA's own statement ten years ago that alcoholism is a disease?

Needed to correct this deplorable condition is education at all levels. First, meaningful education must be included in all medical schools. Secondly, doctors already in the field must be urged to learn as much about the illness as possible, and about the other community resources that can be brought to bear on the complex problems of the alcoholic patient. Physicians must learn that they should share the alcoholic's recovery program with other disciplines. In order to do this they must become familiar with other disciplines.

General hospitals must be urged to offer in-patient detoxification treatment. The acutely intoxicated alcoholic is a person who requires close medical attention to insure that withdrawal from alcohol is not fatal. Too many have died in the gutters, in drunk tanks or in state institutions because community hospitals have discriminated against them.

The medical profession must participate in and contribute to a continuing dialogue on alcoholism with all disciplines concerned about the illness. Such exchange of knowledge and experience will enhance the effectiveness of all those working in the field.

Finally, the medical profession might very well consider the role of specialization in this area. With 6,000,000 alcoholic patients waiting to be helped, an enormous need exists, and specialists can ease the burden on already overburdened general practitioners.

Not all my suggestions will be adopted overnight. And, in the meantime, my frustration will continue, at least for a while, particularly when I think of the 10,000,000 alcoholics who may have died premature deaths over the past twenty years. While their death certificates may not show alcoholism, the real cause of their deaths can be assumed. Is it any wonder that anger boils up when I ask someone to help an alcoholic and I get a shrug of the shoulders or the reply, "Why?" I hear 10,000,000 buried reasons cry back, "Why not?" I pray that physicians will hear the cry for help from the alcoholics still alive, with potential for recovery.

HOOD CONVALESCENT HOME

"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF

CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED

National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM

Certificate Holder—Baltimore County
Fire Prevention Bureau Award

LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800

5313 EDMONDSON AVE.

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected
for possible growth of principal and income.

NO SALES CHARGE

NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

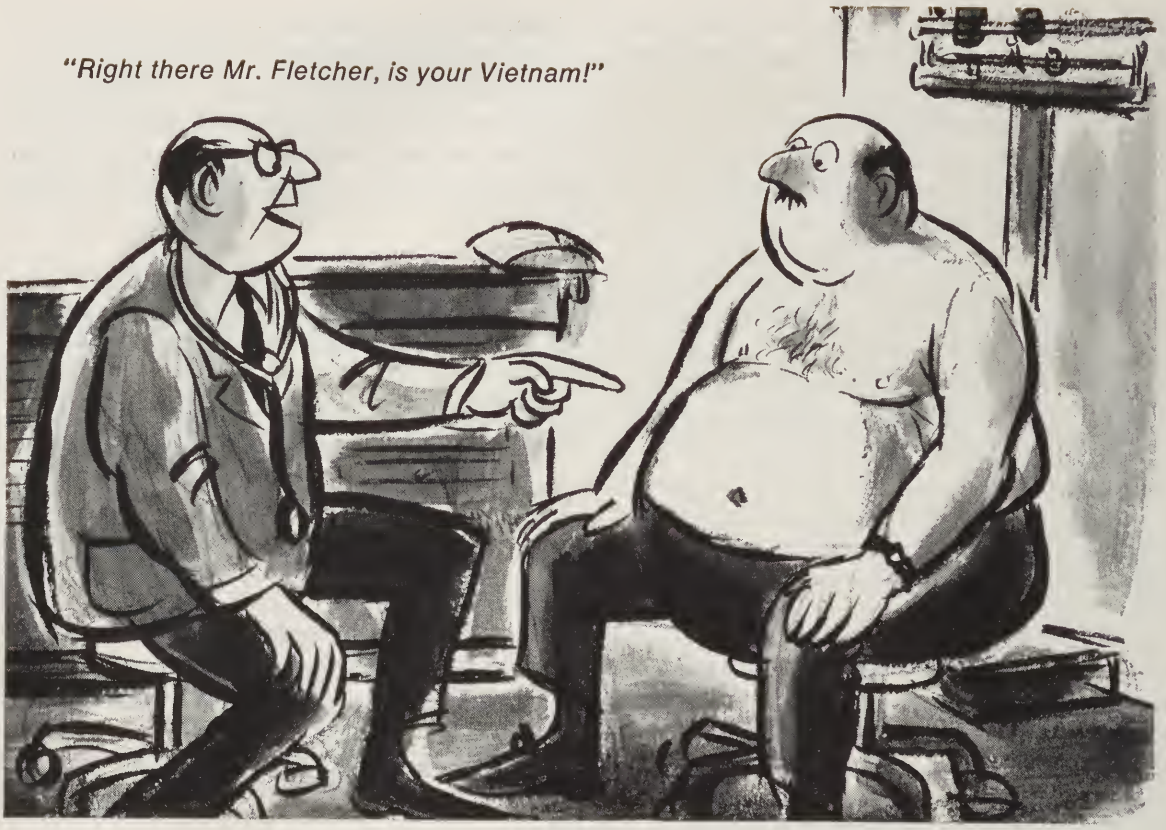
Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

"Right there Mr. Fletcher, is your Vietnam!"



Your cartoon suggestions are invited for this series.

OBETROL®
for weight control

Each OBETROL-10 tablet contains: Methamphetamine Saccharate 2.5 mg.; Methamphetamine Hydrochloride 2.5 mg.; Amphetamine Sulfate 2.5 mg.; Dextro-amphetamine Sulfate 2.5 mg.; (OBETROL-20 tablets contain twice this potency) Pat. #2748052.

This combination of amphetamines may be useful as an adjunct in the management of certain forms of obesity where an appetite depressant is indicated.

Contraindications: Hypertension, advanced arteriosclerosis, coronary artery disease, cardiac arrhythmias, peripheral vascular disease, states of undue restlessness, anxiety, excitement, agitated depression, hyperthyroidism, idiosyncrasy to amphetamine, concomitant administration of a monoamine oxidase inhibitor. **Precautions:** Use with caution in individuals with anorexia, insomnia, vasomotor instability, asthenia, psychopathic personality, a history of homicidal or suicidal tendencies, and individuals who are known to be hyperractive to sympathomimetic agents, or emotionally unstable individuals who are known to be susceptible to drug abuse. Certain monoamine oxidase inhibitors may potentiate the action of Obetrol. **Side Effects:** The most common side effects attended with the use of amphetamines include nervousness, excitability, euphoria, insomnia, dryness of mouth, nausea, vertigo, constipation, and headache.

Dosage and Administration: Initial adult dose is one-half to one 'Obetrol-10' tablet daily, preferably one-half to one hour before meals. This may be gradually increased to one 'Obetrol-10' or 'Obetrol-20' tablet one to three times daily as indicated. **Supplied:** Tablets scored, in bottles of 100. 500, and 1000.

REQUEST SAMPLES AND LITERATURE

OBETROL PHARMACEUTICALS • BROOKLYN, N.Y. 11207

DR. _____

ADDRESS _____

CITY _____ STATE _____

SIGNATURE _____

OBETROL PHARMACEUTICALS
Div. of Rexar Pharmacal Corp., Brooklyn, N.Y. 11207



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Prediction of Performance of Patients with Hip Fracture. #2

"Those who love seldom fail; but our predictability may fail—graphs, charts, formulae—these all may fail. For we know only in part—as yet we have but peep-holes into realities—and we predict only in part; there is always the unpredicted. And when we know more, that which is a part will become obsolete and should be done away with or revised."

Corinthians 1, 13:8. (William Pemberton)

* * * * *

A previous report[1] of 150 hip fractures identified some important findings at initial evaluation which are helpful in the prediction of future perfomance of Activities of Daily Living. A Prognostic Index and score method was presented as a semi-quantitative method of predicting future performance. In this communication, we wish to test the statistical predictors derived from the 150 cases on an entirely new group of 76 patients with hip fracture to see how helpful the data derived from the 150 cases is in predicting results of treatment in the 76 new cases.

Prognostic Index and Score

The weighted values for various initial findings (age, sex, duration, MSCL, and ADL scores, medical prognosis, and diagnostic group) derived from the first 150 cases of hip fracture have been applied to the second group of 76 cases. Table I shows that 98% of the new group of patients with prognostic scores of four or less improved, whereas only 54% of those with scores over four improved. As the prognostic score increased, both the percentage improving and the degree of improvement decreased.

Discriminate Analysis

Discriminate function coefficients were derived from the initial group of 146 cases (four cases could not be used) for age, duration, prognostic group, MSCL and ADL score and diagnostic group and appropriately applied to the second group of 76 patients to derive Z.[2] The patients were then placed in the appropriate final ADL Groups ranked in order and compared with the rank derived from the Prognostic Index Score. Comparison of the ranks derived from the discriminate analysis and from Prognostic Score showed no significant difference. We conclude that discriminate analysis has no advantages for prognostic purposes over the Prognostic Index in this series.

TABLE 1

Prognostic scores derived from previous series (150 cases) applied to new series (76 cases).

Prognostic Score Calculated at Initial Evaluation	Total Cases	Reached Full Independence ADL Score 100	Reached ADL Score 90-99	Reached ADL Score less than 90	Unchanged ADL Score	Deteriorated or Died
0	5	1	3	1		
1	11	6	4	1		
2	8	3	2	3		
3	2	2				
4	13	7	2	3	1	
5	5		2	2	1	
6	3		2	—	1	
7	5		3	1	1	
8	3	1			1	1
9	4	1		2	1	
10	4			2	2	
11	3			2	1	
12	4			2	1	1
13	2				2	
14	2				2	
15	2				1	1
Total	76					

Correlation Coefficient

As with discriminate analysis, correlations of coefficient matrix are not strictly applicable to ordinal scales. Except to confirm that the final ADL score group was strongly influenced by age, MSCL and ADL scores, little came out of this analysis.

Summary

Elaborate statistical methods do not yield information of prognostic value in our patients with hip fracture superior to the Prognostic Index as described previously.[2] However, there is no assurance that a Prognostic Index worked out for one hospital will apply to another, nor that there may not be subtle changes in the selection of patients invalidating the Prognostic Index in the same hospital with time.

—O—

REFERENCES

1. Carroll, D.: Prediction of Performance of Patients with Hip Fracture #1. *Maryland State Medical Journal*, Vol. 18, No. 1, 69-74, January, 1969.
2. Mathematical Program M.012 Johns Hopkins Computer Center.


Help for the Alcoholic:
HIDDEN BROOK
Understanding care in an atmosphere conducive to Recovery
Request Brochure. Call 734-7554
Thomas Run Rd. Belair, Md. 21014

Al-Lin Ambulance Service
"AT THE BELTWAY"
4811 E. LEEDS AVE. BALTIMORE, MD. 21227
24 Hour Emergency Ambulance and Oxygen Service
Trained and Experienced Personnel
2 Way Radio Controlled
247-2111

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

"Your Family Doctor" Celebrates 20 Years On TV

On December 22, 1968 the jointly sponsored "Your Family Doctor" television series produced by the Baltimore City Health Department and the Medical and Chirurgical Faculty celebrated its 20th year on WMAR-TV.

The series, inaugurated December 18, 1948, is not only the oldest continuously produced medical-health television program series but also has one of the longest consecutive runs for a television series of any type—the anniversary program being number 1,005. Additionally it can be said that the Medical Faculty and the City Health Department had the foresight to recognize the great potential of TV in health education at that early date and there is no doubt that this series has contributed immeasurably to the successful health drives conducted through the years and to the health of the citizens of our city and state.

Joining in the anniversary program commemorating the program's years of service and rededication were Emerson R. Julian, MD, chairman of the health committee of the Baltimore City Council, who represented the Mayor; Arthur G. Siwinski, MD, President of the Medical Faculty; Huntington Williams, MD, former Commissioner of Health of Baltimore City (retired) who was instrumental in the establishment of the program; Robert E. Farber, MD, present Commissioner of Health, and Mr. Robert B. Cochrane, Assistant General Manager of the station.

The following is from the anniversary telecast titled "Souvenirs of 20 Years." Dr. Worthington, played by Jack Redfern, Chief of Community Health Information is named for Baltimore's first Health Officer, Dr. John Worthington, appointed by Governor Thomas Sim Lee in 1792 to help prevent the spread of yellow fever from Philadelphia to Baltimore.

DR. WORTHINGTON: Today we are going to have a look at some of the television souvenirs of 20 years and my first guest is Dr. Huntington Williams, retired Commissioner of Health of Baltimore City.

Dr. Williams, in your 30 years as Commissioner of Health you were a strong advocate of health education, would you tell us about the beginnings of the "Your Family Doctor" series?

DR. WILLIAMS: Yes, Dr. Worthington. During those 30 years it was my belief that public health can only be successful if people know what is being done by their health department and what they can do about their own individual health. So we devised a program with five basic aims which are: (1) to promote an understanding of how to keep well, (2) to encourage consultation with the family doctor, (3) to present public health problems, (4) to inform the public of City Health Department activities, and (5) to demonstrate how the family physician and the health department work together.

To carry out these ideas we ran a weekly radio series which began in January 1932. With the advent of television and shortly after WMAR-TV first opened we began the weekly telecast of a similar program on December 15, 1948. That

makes this the oldest continuous medical TV program in the world. The first program had as its guests the father of our present Mayor of Baltimore, Mayor Thomas J. D'Alesandro, Jr.; Dr. Charles Maxson, the President of the Medical and Chirurgical Faculty of Maryland; Dr. Walter D. Wise, Chairman of the Faculty Council and myself. The Mayor at that time stated, "I am glad to see that these new efforts are being made to bring health instruction to the people and would thank the physicians of Maryland and the officials of the television station for their interest and support."

DR. WORTHINGTON: The program was, then, as successful as hoped.

DR. WILLIAMS: Indeed so, its influence went far beyond just citizens of Baltimore and Maryland. In 1952 it received an award from the Institute of Educational and TV Programs, Ohio State University at the 16th American Exhibition of Educational Radio and TV Programs. Here is the award as shown by Mr. Robert Cochrane of WMAR-TV to Mr. Gordon, Director of our Bureau of Health Information, Dr. George Yeager of the Medical and Chirurgical Faculty and me. This demonstrates the program's ability to have an effect far beyond the mere confines of the local area covered by this TV station. Practically every year some organization or other either in or outside the United States sends for information on how to do similar TV programs. Two years ago films of the Family Doctor program were used for a symposium for health officers and physicians in Canada to encourage the use of TV for public health education there. From time to time foreign students from The Johns Hopkins School of Hygiene and Public Health have come to perform on the program or to observe and learn, then have returned to their countries with an increased admiration of the value of educational TV in promoting health. What's more, the program is well known to the officials of the World Health Organization. One of them, Dr. Lennart Hesselvik, did one program with us in 1958 and, of course, we have worked in close cooperation with the World Health Organization all the years the program has been on. So we can say that "Your Family Doctor" has exceeded our greatest expectations.

DR. WORTHINGTON: Thank you, Dr. Williams, and now I would like to talk next to Dr. Arthur Siwinski, President of the Medical and Chirurgical Faculty of Maryland. Dr. Siwinski as cosponsor of the "Family Doctor" program the Medical and Chirurgical Faculty has certainly assisted greatly in many ways to provide the public with health education.

DR. SIWINSKI: Yes, many of the guests on the program are drawn from the Faculty and sometimes props are borrowed from our Medical Museum, but I would like to speak of some of the state-wide programs of preventive medicine in which this series has played a large part.

DR. WORTHINGTON: First of these was the Salk Polio Campaign, wasn't it?

DR. SIWINSKI: Yes, Dr. Worthington. Polio was a major health problem in those days, and when Jonas Salk developed a preventive vaccine, it was necessary to inform the public of what was needed to prevent this disease. The mass media were used extensively and the "Family Doctor" program made an important contribution to the success of the program.

DR. WORTHINGTON: Another preventive medicine campaign on the "Family Doctor" program has been the annual Diabetes Detection Drive.

DR. SIWINSKI: True, Dr. Abraham Silver, has been very active in the Medical Society's efforts to detect unknown diabetes. The "Family Doctor" program has helped to promote a sizable turnout for the tests.

On an even larger scale was the state-wide Sabin Oral Polio Vaccine Drive in 1963 in which the "Family Doctor" program and WMAR-TV showed the public how easy it is to get protected against polio. The success of this drive is pointed out by the almost complete eradication of polio in our state.

Then a few years ago the "Family Doctor" took an active part in promoting rabies vaccination in a large portion of Maryland. This campaign was conducted in cooperation with the Maryland Veterinarian Association.

Recently the "Family Doctor" program aided in the state-wide measles vaccination campaign conducted by the Medical Society and the Health Department. This is one of several TV programs presented by "Your Family Doctor". Appearing on this program were Dr. Edward Davens of the Maryland State Department of Health and Dr. Robert E. Farber, the present Commissioner of Health of Baltimore. In short, this TV series has proven a valuable tool in assisting physicians and health officers to attack large problems of

preventive medicine by bringing large scale public cooperation.

DR. WORTHINGTON: Thank you, Dr. Siwinski. Our next guest is the present Commissioner of Health of Baltimore City, Dr. Robert E. Farber. Dr. Farber, although the program was presented principally as teamwork with the private physician, I think you'll agree that an increasing amount of attention has been paid to those health workers who are not physicians.

DR. FARBER: Yes, over the years the Health Department's objective of maintaining and improving the health of the people has increasingly required the assistance of those outside the medical profession. Today we need more sanitarians, nurses, health and social agency workers, and safety engineers to solve many of our health problems. So more recently the "Family Doctor" program has included such guests as members of the Maryland Pharmaceutical Association to talk about safe use of drugs and the problem of drug abuse. On other occasions, the program has been used to recruit young people into careers in the health field. For example, here is a program to recruit more student nurses and there have been similar programs promoting careers in physical therapy, medical technology, dietetics, social work and dental and environmental hygiene.

DR. WORTHINGTON: Of course, this does not mean that the physician has been left out.

DR. FARBER: Not at all. The physician has been consistently called upon to be an educator in preventive medicine. Here is Dr. Allen Voshell explaining the function of the bones of the body, the diseases and injuries that can occur to them and how to prevent or treat such disease and injury.

DR. WORTHINGTON: But in meeting Baltimore's health problems the importance of a team effort must not be overlooked.

DR. FARBER: Yes. Perhaps the best example of this is the problem of preventing child lead paint poisoning which has required not only the physician but many others outside the medical profession to bring about public recognition that lead poisoning in our city is a health problem that each citizen can help eliminate. Here one of our former health officers, Dr. H. Maceo Williams, is discussing the matter on the Family Doctor. It is through the efforts of the mass media, including TV programs like this that has helped to reduce the deaths of Baltimore children from this cause.

DR. WORTHINGTON: Sometimes we tend to forget that the promotion of safety is an important part of maintaining public health too.

DR. FARBER: That's true, Dr. Worthington, but throughout the years the "Family Doctor" program has provided viewers with consistent reminders of the importance of safety in maintaining health.

Here is a show from last year's Christmas season in which Captain McLaughlin of Baltimore's Fire Prevention Bureau demonstrated some danger spots around the home at Christmas time. Other subjects done in cooperation with health agencies are motoring and pedestrian safety, prevention of falls, poison prevention, camping safety, swimming and boating safety, hunting and firearm safety, and eye safety. Thus, the "Family Doctor" TV series has contributed greatly in bringing together in a close working relationship the physician and those outside the medical profession in meeting the City's problems of public health and safety.

DR. WORTHINGTON: Thank you, Dr. Farber. And now it is my pleasure to call on Dr. Emerson R. Julian, Chairman of the health committee of the Baltimore City Council, who is representing the Mayor. III to close our program today.

DR. JULIAN: Thank you, Dr. Worthington. In the betterment of the disadvantaged this series has given public information on the Model Cities Program, the Park Heights Adolescent Project, the work of the Bureau of Special Home Services and as seen here even has involved an entire cast from Morgan State College in the production of a program concerning one of our serious public health problems—tuberculosis. Its annual support of the Spring Clean-up Campaign and Fire Prevention Week won the City Health Department an award this year from the Fire Department. So the program has been at least partially responsible for our Fire Prevention Bureau's high rating among the largest cities of the United States. I might also add that the programs on poison prevention contributed to Baltimore's winning the National Safety Council's "Flame of Life" award some three years ago. But these are past honors. I am informed that "Your Family Doctor" is planning support for a major effort toward solving inner city health problems such as malnutrition and sanitation, and I have high hopes that in these efforts it will be as successful as it has in past campaigns. So at this time I would like to thank the physicians of Maryland for their sup-

port of this television series and as spokesman for all concerned with the production of the "Your Family Doctor" series to offer to Mr. Robert B. Cochrane, Assistant General Manager of WMAR-TV, this plaque in tribute to the 20 years of public service rendered by the staff of this station.

The wording is as follows: *"To WMAR-TV for 20 years of public education in preventive medicine, public health and safety on the weekly TV series, "Your Family Doctor"—The Baltimore City Health Department and the Medical and Chirurgical Faculty of Maryland."*

MR. COCHRANE: Thank you very much, Dr. Julian. I accept this on behalf of WMAR-TV with a pleasure as unique as the program itself. I don't think many programs in all of television can boast a record of 20 years and more than a thousand telecasts and I believe its value in medical education and medical information to the community has been incalculable. Thank you very much.

Following Mr. Cochrane's acceptance the program was concluded in the usual fashion by Dr. Worthington thanking his guests and the program sign-off reminder to viewers to "Remember to learn to do your part in the prevention of disease."

"Your Family Doctor" is prepared and coordinated by the Bureau of Health Information in the Baltimore City Health Department guided by a TV Committee comprised of both Health Department and Medical Faculty members. Scripts are written by Mr. John Stidman of the WMAR-TV staff. Production is supervised by Mr. Joseph Gordon, Director of the Bureau of Health Information and Mr. Jack Redfern.

Opportunity is afforded here to extend gratitude to the many physicians and health workers who have cooperated through the years in this unique health education series.

LDG
LUCAS DESIGN GROUP



Contract Interior Design Division of Lucas Bros., Inc.
221 East Baltimore St. ■ MU 5-3000

STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

We Repair and make Lamps
"Lamps make the home Beautiful"
LE 9-0222
403 N. Charles Street
Baltimore, Md. 21201

TOURS ARRANGED TO MEDICAL CONFERENCES AND CONCLAVES
Domestic and International
GLOBETROTTER TRAVEL
A Professional Travel Service
BALTIMORE: REISTERSTOWN ROAD PLAZA • 358-6444
BALTIMORE: MONDAWMIN SHOPPING CENTER • 669-8200
WASHINGTON: WHEATON PL. SHOPPING CTR. • 949-1700

A & F Nurses Registry



Registered & Licensed

LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

For Private Home Hospitals Institutions
D. S. Anderson, Mgr. Dir.
24 Hour Service
613 E. 32nd St.
613 Homestead St.
BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

COLOSTOMY
ILEOSTOMY
Appliances and Disposable Bags
CALL
FIELDS PHARMACY
IN PIKESVILLE
for convalescent supplies and service
FOR RAPID DELIVERY
486-3300



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

The Art of Medicine

"The art has three factors, the disease, the patient, the physician. The physician is the servant of the art. The patient must cooperate with the physician in combating the disease."

Hippocrates "Epidemics"

This quotation is one of the eternally true statements of Hippocrates, as evidenced by these titles:

The human side and the business side of medical practice. (AMA); Patients and their doctors. (Cartwright); The doctor, his patient, and the illness. (Balint); The management of the doctor-patient relationship. (Blum); Privileged communications between physician and patient. (DeWitt); Death and dying; attitudes of patient and doctor; The psychology of medical practice. (Hollender); The doctor, his career, his business, his human relations. (Truman); The changing patient-doctor relationship. (Vorhaus).

* * * * *

News of *Medical Libraries*

Dr. Louis Krause is recovering from a broken hip suffered this last summer. He says he is now able to get outside with help and hopes to be able to attend Library Committee meetings soon. Dr. Krause is the former chairman of the Medical & Chirurgical Faculty Library Committee.

* * * * *

Mr. Alfred N. Brandon, Director of Welch Medical Library, Johns Hopkins School of Medicine, has announced that as of the end of June he will become director of Mt. Sinai School of Medicine Library, New York and Professor of medical librarianship. Baltimore medical and library communities will regret to see him leave the area, but wish him success in a very challenging position.

* * * * *

Mr. Ray Palmer, of the Welch Medical Library staff, left the last of January to become assistant to Mr. Harold Bloomquist, recently appointed, Director of Countway Library, Boston, Massachusetts. Countway is the combined libraries of the Harvard Medical Library and Boston Medical Library.

* * * * *

New Accessions: Books

(arranged by author and title)

Adair, Fred Lyman
The country doctor and the specialist. Maitland, Florida. Adair Award Fund, 1968.

Advances in internal medicine . . . V. 14
New York, N. Y., Intersciences publishers, inc. 1968.

American Geriatrics Society Seminar.
Distinguishing the health care needs of the aging: proceedings of the American Geriatrics Society Seminar, Southern Pines, N. C., March 12-14, 1967. American Geriatrics Society, 1968.

American Hospital Association.
Infection control in the hospital. Chicago, American Hospital Association, 1968.

Andrewes, Sir Christopher Howard.
Viruses of vertebrates. Baltimore, Williams & Wilkins, 1967.

Bisseru, Balideo
Diseases of man acquired from his pets. Philadelphia, Lippincott, 1967.

Bjure, Jan
Pulmonary diffusing capacity for carbon monoxide in relation to cardiac output in man. Goteborg, Flanders Boktryckeri Aktiebolag, 1965.

Christopher, Frederick
Textbook of surgery, 9th ed. Philadelphia, Saunders, 1968.

Ferguson, Albert Barnett
Orthopaedic surgery in infancy and childhood. 3d. ed. Baltimore Williams & Wilkins, 1968.

Gorney, Roderic
Reflections on the new biology. (Reprinted from U.C.L.A. *Law Review* v. 15, no. 2, p. 267-550)

Hall, Charles Alfred
The blood in disease. Philadelphia, Lippincott, 1968.

Hirata, Isao
The doctor and the athlete. Philadelphia, Lippincott, 1968.

Horemis, George
Medical boards examination questions and answers.

Hospital Council of Maryland, Inc.
Facts about medicaid. Towson, Maryland. Hospital Council of Maryland, Inc., 1968.

Irvine, W. James ed.
Thyrotoxicosis. Proceedings of an International Symposium. Edinburgh, May, 1967. Baltimore, Williams & Wilkins, 1967.

Liechty, Richard D.
Synopsis of surgery. St. Louis, C. V. Mosby Co., 1968.

Loraine, John A.
Fertility and contraception in the human female. Baltimore, Williams & Wilkins, 1968.

Lyght, Charles E. editor
Reflections on research and the future of medicine: a symposium and other addresses. New York, McGraw-Hill, 1967.

National Aeronautics and Space Administration.
Medical benefits from space research. Washington, National Aeronautics and Space Administration, 1967.

National Education Association. The American Association for Health, Physical Education and Recreation.
Drug Abuse: escape to nowhere. A guide for educators. Philadelphia, Smith, Kline and French Laboratories, 1967.

National Research Council. Committee on Brain Sciences.
IBRO Survey of research facilities and manpower in brain sciences in the United States. Washington National Academy of Sciences, 1968.

Norton, Doreen
Hospitals of the long-stay patient; a study of their practical nursing problems and solutions. 1st. ed. Oxford, New York, Pergamon Press, 1967.

Penchansky, Roy, compiler.
Health service administration; policy cases and the case method. Cambridge, Harvard University Press, 1968.

Plumbe, Wilfred John
The preservation of books in tropical and subtropical countries. London, Oxford University Press, 1964.

Robinow, Beatrix H.
Outline for the organization of hospital libraries. Toronto, Canadian Hospital Association, 1967.

Sagher, Felix
Mastocytosis and the mast cell. Chicago, Year Book Medical Publishers, 1967.

Semmens, James P.
Teen-age pregnancy, including management of emotional and constitutional problems. Springfield, Illinois. C. C. Thomas, 1968.

Stone, Moses Jacob
The diagnosis and treatment of pulmonary tuberculosis. Philadelphia, Lea and Febiger.

Stradling, Peter
Diagnosis bronchoscopy: an introduction. Edinburgh, London, E. & S. Livingstone, 1968.

Thomson, William Archibald Robson
Sex and its problems. Edinburgh, London, E. & S. Livingstone, 1968.

Union list of serials in libraries of the United States and Canada. 3d. edition. New York, H. W. Wilson Co., 1965.

U.S. National Institutes of Health Library. Translations Index. Bethesda, U.S. Public Health Service, 1967.

U.S. Public Health Service.
The Framingham study, an epidemiological investigation of cardiovascular disease. Bethesda, Maryland. U.S. Public Health Service, 1968.

U.S. Public Health Service. Division of Regional Medical Programs. **Guidelines, Regional Medical Programs, revised May, 1968.** Bethesda, Public Health Service.

U.S. Public Health Service. Tuberculosis Program.
Tuberculosis beds in hospitals and sanatoria. An index of beds available, June 30, 1967. Atlanta, National Communicable Disease Center, 1968.

The Underachiever; a guide to tutorial, remedial, diagnostic, and academic resources in prep school programs and clinics. 1st. ed.

The Year book of anesthesia. 1968.
Chicago, Year Book Medical Publishers.

Young, Clara Gene
Learning medical terminology step by step. St. Louis, Mosby, 1967.



MRS. HARRY L. BERMAN, EDITOR

National President to Install Officers in April

Mrs. Clifton C. Long, National President of the Woman's Auxiliary to the AMA, has graciously accepted our invitation to address our Annual Meeting and install our incoming officers on April 10, 1969, at the Belvedere Hotel. Do plan ahead to join us in welcoming Esther. Mark your calendars now.

Mrs. Long of Ozark, Arkansas was installed as president of the Woman's Auxiliary to the American Medical Association at the 45th annual convention in June 1968, in San Francisco, California, after completing her term as president-elect. She has contributed to the national auxiliary since 1961 when she was southern regional health careers chairman. She served three years as national rural health chairman, 1962-64, and two years as a first vice president, 1965-67.

On the state level, she has held various chairmanships including community service, legislation, program and safety. She served as state president in 1960-61, and also was president of her county auxiliary.

Esther Callahan attended Topeka, Kansas, grade and high schools, Washburn College and Kansas University, where she met and married Clifton C. Long in 1940. While he attended medical school at the University of Arkansas, Mrs. Long worked as a secretary to the anatomy and chemistry departments at the school.

Dr. Long is an abdominal surgeon and chief of staff at the Turner Memorial Hospital in Ozark. At the present time he is a city alderman and on the local school board.



Mrs. Long

Dr. and Mrs. Long have four children: Cliff III, age 24 (married), is a student at Arkansas Tech School of Business, majoring in hospital administration; Mary (Mrs. James L. Gardner), 22, recently received a degree in elementary education from Southeastern Louisiana College; Joan, 18, has just graduated from Ozark High School and is interested in the medical field, and June, 16, is a junior at Ozark High School.

Mrs. Long has served her community as PTA president, WSCS president and chairman, Garden Club president and Community Improvement chairman. She was selected as Citizen of the Year in 1956 for Ozark, named life member to the WSCS of the Methodist Church, named Arkansas Woman of the Year in 1964 by the *Progressive Farmer,* and awarded the honorary degree of the Chapter Farmer by the Ozark FFA in 1964. She was responsible for starting brownie, girl scout and cub scout programs in Ozark, and served as leader for all of the groups in past years. She was appointed to the Board of the Arkansas Training School for Girls in 1961, serving as vice-chairman of the Arkansas Juvenile Training School Board which governs all training schools for delinquent children in the state. In 1968 she was appointed to the Arkansas Commission on the Status of Women.

We are most appreciative of Esther's tireless efforts on behalf of medical society auxiliaries throughout the country, and especially of her willingness to travel so far to be with us. Let's all give her the tribute she deserves by turning out to hear her in April.

Distinguished Dining
Whenever the holidays,
Whatever the reasons,
It's the

Olney Inn

The Inn for all seasons.

And for an "Adventure in Shopping," be sure to visit the Inn's BARN SHOP. Antiques, Reproductions, Imports, Contemporary Gifts.

30 minutes from downtown Washington
Rte. #97 – Georgia Ave., Olney, Md.
From Baltimore, Rte. #29—#108—#97
For Reservations — Phone: 929-1717

Growing Feet Can Have Problems!



PRONATION KNOCK-KNEES PIGEON-TOES

These common problems can be helped with proper shoes, correctly fitted.

Prescriptions Carefully Filled

VAN DYKE & BACON

307 N. Charles St. SAratoga 7-3775
5849 York Rd. IDlewood 3-1100
Baltimore, Maryland

"The Best of Care for Those You Love"



Pleasant Manor
CONVALESCENT AND NURSING CENTER

ONE OF THE NEWEST, MOST MODERN PARA-MEDICAL FACILITIES

Round-the-clock care by Professional Staff
Complete Intensive Care Units
Physical and Occupational Therapy
Excellent Meals--Kosher Food on Request
Air-Conditioned, Fire-resistant Building
Centrally Located Near Sinai Hospital
Your Inspection Invited

4615 PARK HEIGHTS AVE. BALTIMORE, MD. **542-4800**

See next page for prescribing informatio



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specific in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strain may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged actio permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocol pruritus ani. Skin—maculopapular and erythematous rashes; a ra case of exfoliative dermatitis has been reported. Photosensitivit onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, some times accompanied by thirst (rare). Hypersensitivity reactions—urt caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (ye low-brown) in children of mothers given this drug during the latter ha of pregnancy, and in children given the drug during the neonatal per od, infancy and early childhood. Enamel hypoplasia has been seen i a few children. If adverse reaction or idiosyncrasy occurs, discontinu medication and institute appropriate therapy. Demethylchlortetra cycline may form a stable calcium complex in any bone-forming tissu with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Shoul be given 1 hour before or 2 hours after meals, since absorption i impaired by the concomitant administration of high calcium conten drugs, foods and some dairy products. Treatment of streptococc infections should continue for 10 days, even though symptoms hav subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 30 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

396

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle



heavenly relief
for unearthly cough

Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.



ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

MEETING NOTES

Nine of the members of the Board of Directors of the Baltimore City Medical Society met at 1211 Cathedral Street, December 3, 1968, at 4:30 PM. The meeting was called to order by D. Frank Kaltreider, MD. The minutes of the November 12th meeting were read and approved by the Board. Mrs. Karl Mech, President of the Women's Auxiliary of the Baltimore City Medical Society, was asked to appear before the Board in response to a letter sent from the Women's Auxiliary to the Baltimore City Medical Society requesting economic assistance. Mrs. Mech presented the problems confronting the Auxiliary with regard to operational expense. During the next fiscal year, beginning May, 1969, it is anticipated by the Auxiliary that it will be operating at approximately a one-thousand-dollar deficit. The budgetary requirements and income of the Auxiliary were presented in detail and the obvious economic deficit was discussed. The Board of Directors unanimously agreed that the ladies of the Women's Auxiliary are doing excellent, worthwhile, and constructive work, and the Board sympathized with their dilemma. After some consideration, it was decided that the incoming President, Raymond C. V. Robinson, MD, would select a committee to study the problem confronting the Women's Auxiliary and to make appropriate recommendations to the Board of Directors.

The next item on the agenda was the selection of nominees for the various appointments to be made from the Baltimore City Medical Society to The Medical and Chirurgical Faculty of the State of Maryland. These recommendations were as follows:

1) Donald W. Mintzer, MD, was nominated for consideration by the President-elect to The Professional Medical Services Committee as representative from the Baltimore City District.
2) No nominee was named from the Baltimore City Society to be considered for the Community Service Award to be presented at the annual meeting in 1969.
3) Howard Moses, MD, was nominated as representative from the Baltimore City Medical Society to serve on the Faculty's Legislative Committee during the 1969 General Assembly in Annapolis.
4) John N. Classen, MD, and Raymond C. V. Robinson, MD, were nominated as representatives to serve as liaison officers to the local news media during 1969.
5) John M. Dennis, MD, was nominated as a practicing physician nominee for possible inclusion in a list to be submitted to the Governor. From this list the Governor will select two physicians to serve on the Commission on Medical Discipline.

The next item on the agenda, presented to the Board of Directors, was a request for endorsement of a radio program entitled "Doctors' House Call." This program is commercially sponsored by the Giant Pharmacies, a Division of Giant Foods, Inc., and is presented in cooperation with the American Medical Association. The Board of Directors decided that, although the program agenda sounded worthwhile, they felt they could not support a private industrial-sponsored program.

A request from William Sawyer, MD, that his dues for 1969 be waived because of illness was unanimously granted by the Board.

Next was the presentation of the proposed budget for 1969 of the Baltimore City Medical Society. This report was submited by Emmanuel A. Schiminek, MD, Treasurer of the Baltimore City Medical Society.

Under new business, the Board of Directors agreed to submit a donation of $100 to the Student American Medical Association in accordance with the past practice of the Society.

Correspondence to the Board of Directors from Chief Martin McMahon of the Baltimore City Fire Department explained the present standardization of procedure concerning ambulance service in the city of Baltimore. Details of this standardization of operation will be sent to the members of the Society with the next mailing of correspondence.

This being the last meeting of the Board of Directors under the chairmanship of Dr. Kaltreider, the meeting was closed with his grateful acknowledgment to the Board of their cooperation during his term as President of Baltimore City Medical Society. The meeting was adjourned at 6:00 PM.

Income

	Actual 1968 Income	Anticipated 1969 Income
Dues	$37,355.00	$37,000.00
Interest	805.00	800.00
TOTAL INCOME	$38,160.00	$37,800.00

Expenses

	Actual 1968 Expenses	1969 Proposed BUDGET
Medical & Chirurgical Faculty	$25,943.00	$26,000.00
Association Dues	125.00	125.00
Auditor	293.70	350.00
Meeting expenses	423.09	1,000.00
Postage, Printing, Stationery	3,712.15	4,500.00
Office Supplies	290.42	400.00
Equipment Maintenance	102.24	200.00
Miscellaneous Expenses	49.19	300.00
Public Medical Education Com.	.....	200.00
Legal expenses	.....	500.00
	$30,938.79	$33,575.00
SURPLUS	$ 7,221.21	$ 4,225.00

THE BIG DATSUN DIFFERENCE



96 H.P., overhead cam, bucket seats, 4 speed or auto. trans.

$1866.00 P.O.E.



96 H.P. O.H.C. Bucket seats, 4 speed or auto. trans., disc brakes.

$1996.00 P.O.E.



White sidewall tires, heater and defroster, backup lights, bucket seats, 4-spd. synchromesh trans.

$2196.00 P.O.E.



Best in its class. Bucket seats, 4 speed ind. rear suspension.

$2766.00 P.O.E.

TOWN & COUNTRY MOTORS

8021 HARFORD ROAD 1 mile S. of Beltway Exit 31 665-7500

Book Reviews

INSTRUCTIONS FOR PATIENTS, H. Winter Griffith, MD; The W. B. Saunders Company, Philadelphia, Pa. 1968.

This collection of instruction sheets presents a simple method of putting into the patient's hands pertinent material about his medical problems. These can be read and reread at a time and place of his choice. The sheets will not take the place of talking to the patient, but they may make it possible to talk with the patient just once.

This loose-leaf binder will make a welcome addition to any physician's office; as a carte blanche is given the physician for making copies on his own copying machine.

QUESTIONS AND ANSWERS ON CONTACT LENS PRACTICE, Jack Hartstein, MD, The C. V. Mosby Company, St. Louis, Mo. 1968.

This book is essentially a compilation of practical information in contact lens fitting and is an outgrowth of material gathered in preparation for lectures and seminars given at various institutions. It provides the beginning practitioner with a detailed step by step procedure in the work-up and care of the contact lens patient, and provides essential information in a concise and readily available manner.

This book is a worthwhile addition to any medical library.

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

FREE GIFT For taking a test drive. Come in and inspect our beautiful new facilities.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL
5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545

Average Salary for Hospital Personnel

The *New York Times* reports that the average salary for all hospital personnel was $5,140 in 1967. The AHA estimates there will be a 25% increase in average salary over the next two years, and that the number of full-time employees will increase by 5.1%. This means that by 1970 the annual hospital payroll for the voluntary hospitals alone will be very close to 9 billion dollars!



WHEN YOUR PATIENTS NEED NURSING CARE

Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED

24 HOUR SERVICE ESTABLISHED 1935

BALTIMORE, MARYLAND 21229

MERCEDES-BENZ

Baltimore's only Authorized Dealer for Sales, Service and Parts

R. & H. Motors, Inc.

4810 Belair Rd. 426-9200

Baltimore, Md. 21206

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery MU 5-3232

D. Stuart Webb

Advertising Services, Inc.

306 N. Gay Street Baltimore, Md. 21202

ACHROMYCIN® V
TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

Suspected tetracycline-sensitive infection?

While waiting for the results of the sensitivity test, start the therapy likely to succeed...

Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

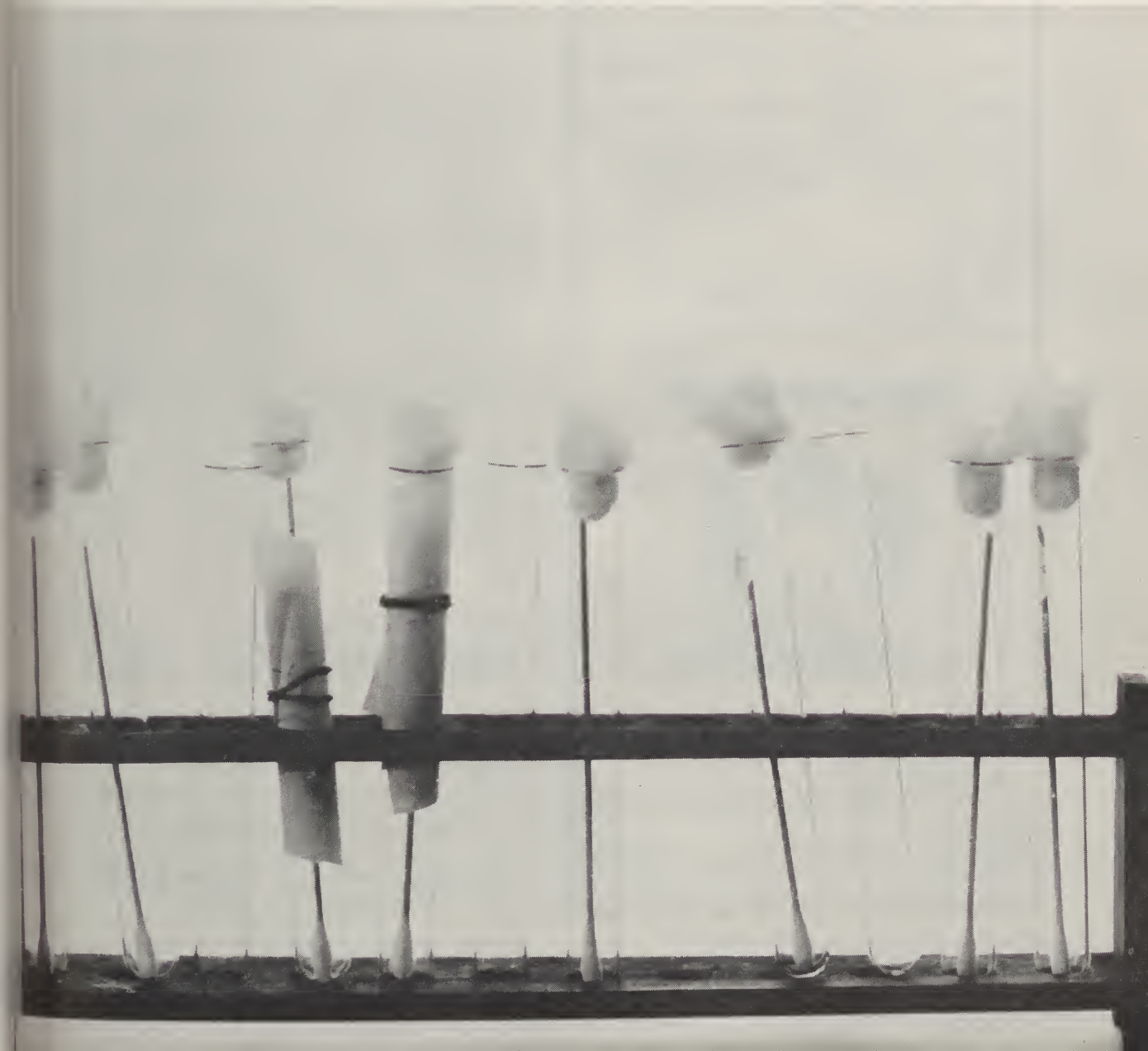
Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

—Prescribing Information

ACHROMYCIN® V
TETRACYCLINE

Lederle

The price differential is inconsequential.



Skilled Hands That Care



Twenty four hours a day . . . in bright, modern facilities, the aged, chronically ill and convalescent, receive professional care, nutritional balanced foods . . . and occupational and recreational therapy programs.

Competent registered nurses see that your instructions are followed exactly.

HOUSE IN THE PINES
NURSING HOMES

Baltimore, Md.
BEL-AIRE—5837 Belair Road.....CL 4-8800
BELVEDERE—2525 W. Belvedere Ave.....FO 7-9100

Catonsville, Md.
CATONSVILLE—16 Fusting Ave.....RI 7-1800

Easton, Md.
EASTON—Rt. 50 & Dutchman's Lane.....TA 2-4000

Your Inspection Invited—Brochure Upon Request

Modular Room to Provide

A room-within-a-room, specifically designed to provide a germ-free environment for patients with cancer during intensive anti-tumor therapy, is being developed for the National Cancer Institute by Litton Industries' Applied Science Division in Minneapolis, Minnesota.

Technically called a laminar flow patient isolator, the unit will be of modular design to fit into almost any hospital room presently accommodating two or more beds.

In a day's time a standard two-bed hospital room can be turned into a single-bed isolator care unit.

A $196,000 developmental contract was awarded to the Division late in June 1968 by the National Cancer Institute, a component of the National Institutes of Health (NIH), Bethesda, Maryland. NIH is an agency of the U. S. Department of Health, Education and Welfare (HEW). The program is under the direction of William Z. Penland who is project officer for the National Cancer Institute and Dr. Seymour Perry, Associate Scientific Director for Clinical Trials, NCI. The first units will undergo clinical testing in the Chemotherapy Area of the National Cancer Institute beginning in June 1969.

The germ-free environment created within the room will not only make possible more intensive treatment of patients with cancer, but it will also be suited for treatment of individuals with extensive burns; patients who have received heart, kidney or other transplants; and still other patients who are at high risk to infection. The sterile environment provided by these units would be vital to their well-being.

SKILL SURGICAL, INC.

SKILL

SUPPLIES & EQUIPMENT
for
PHYSICIANS—SURGEONS
HOSPITALS

5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

Germ-Free Environment

The room will also have an inherent capability for containing micro-organisms, if so desired, and thus could be used to isolate patients with communicable diseases.

Key to the germ-free environment is the laminar flow design in which air passes through the room in a straight line and in a single direction. Thus, the air in front of the patient at any given moment is continuously clean and on the move, although he is not aware of air in motion. All of the air in the room is completely filtered six times each minute, or once every ten seconds.

Studies indicate that the laminar flow design can reduce the number of airborne organisms from 4,000 per 1,000 cubic feet of air to one per 1,000 cubic feet of air.

The laminar flow method is less confining and should enable the patients to remain under intensive care for a longer time, even for months if necessary.

Basic to the room is a bank of high efficiency particle arrestors (HEPA) filters, forming one of the walls. Structures for other walls are being evaluated—some include windows, others are designed for pass-through and storage. Wall modules will be of various sizes, with standard fittings to facilitate adapting them to hospital rooms. Also in the design evaluation stage is furniture for use within the room. It must be functional as well as psychologically acceptable, and must not disrupt the flow of air through the room.

The filter unit is designed to meet Air Force specifications, and will operate at 99.97% down to 0.3 micron efficiencies—a range that includes the trapping of bacterial particles.

Visit the #1 Spot for Your Diet Needs

Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)

For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic

SPECIAL DIET SHOP
Phone SA 7-0383

NOW
A NEW CONCEPT
in
BOOKEEPING
and
TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

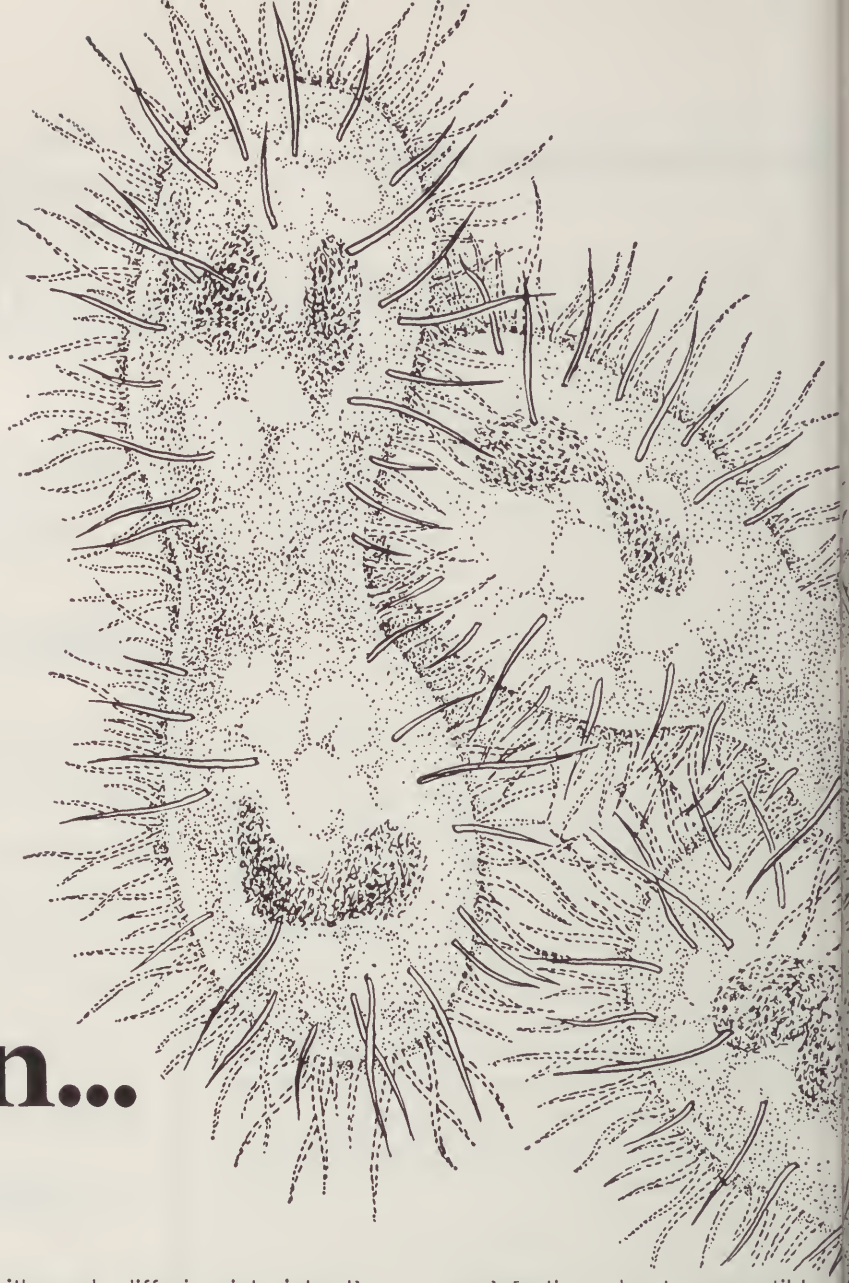
—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

FEDERATED BUSINESS SERVICES, INC.

Box 580
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager



A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine,* ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

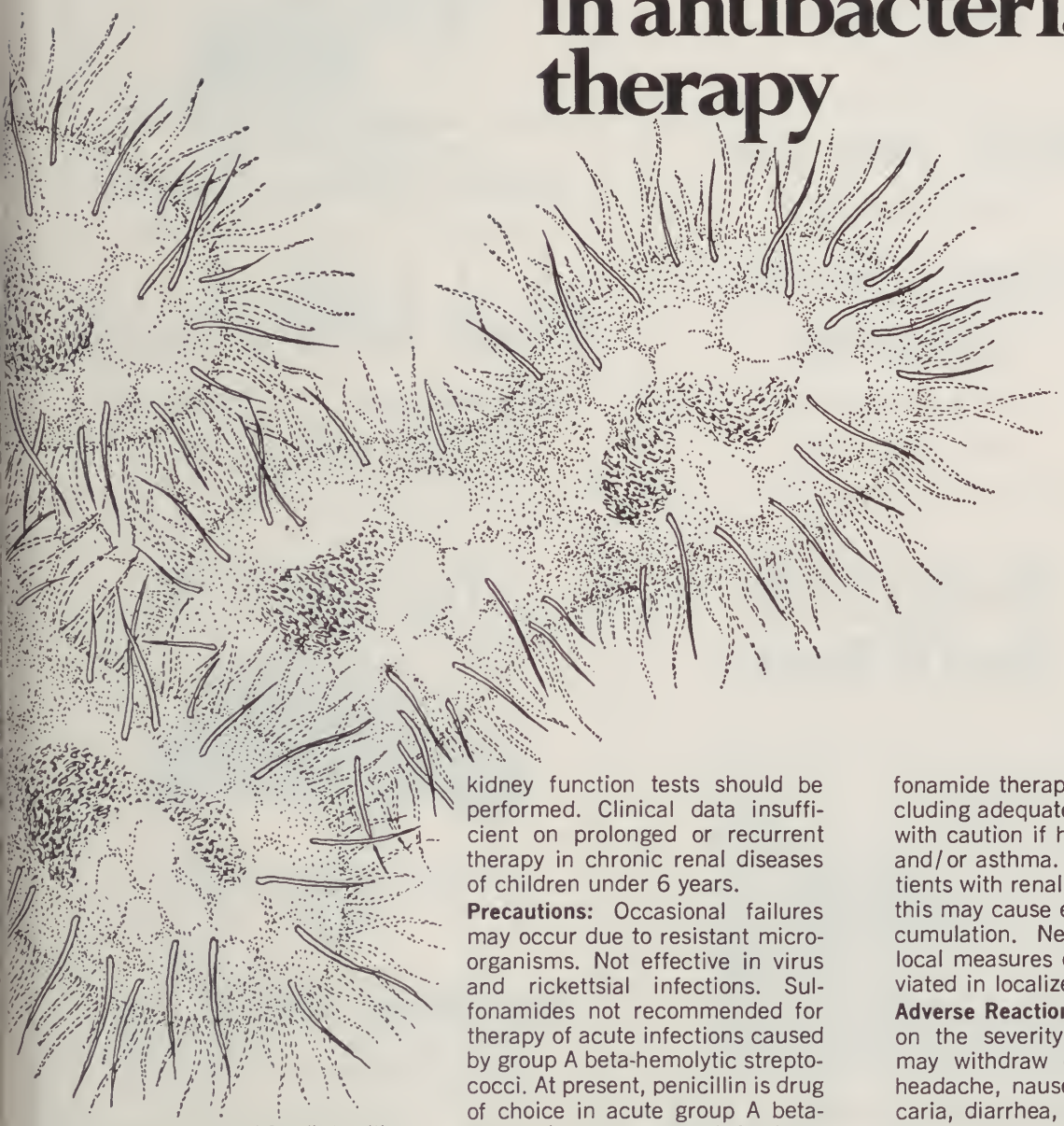
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days*. Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

DOCTORS' OFFICES

LARGE

MEDIUM

SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST. CORPORATION

11 E. Chase St.

Phone 539-8553



PLANNING, ENGINEERING, INSTALLATION & SERVICE

We Feature **AMPEX**

VIDEOTAPE RECORDING EQUIPMENT

Call Today for a Free Demonstration

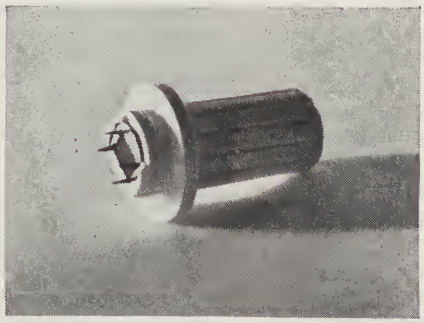
high fidelity house

6307 YORK ROAD *(Drumcastle)* **BALTIMORE, MD.**

Phone 323-3713

To fight TB- find it first!

Make tuberculin testing routine with every physical examination.



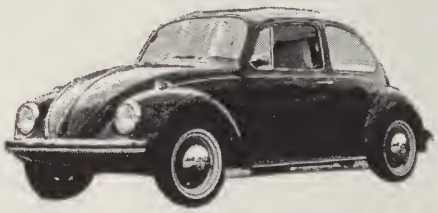
TUBERCULIN, TINE TEST (Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.

Lederle

330—8/6135

VOLKSWAGEN



Hobelmann Motors, Inc.

AUTHORIZED DEALER

Bank Financing

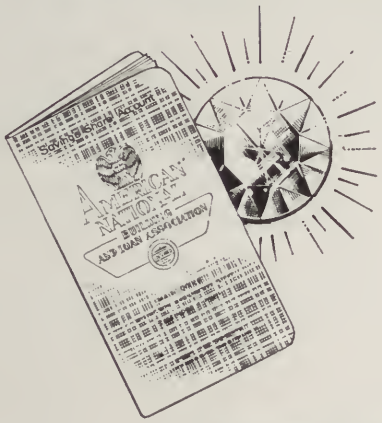
814 Light St.—Baltimore, Md. 21230

727-4400

Open 9 to 9

The G-E-M of a Plan Brings You
Big Rewards 4 Times Yearly:

Dividends Now Paid Quarterly!



Every season is an added reason to save at American National: you'll be rewarded for your foresight *four times a year*, with dividends payable February 1st, May 1st, August 1st, and November 1st. Thus our GEM of a Plan does even greater things for you!

Here, you Gain Every Month and *keep what you gain*, because we continue to calculate your dividends on a MONTHLY BASIS. Even if you withdraw part of your funds, you still receive the dividends of previous months, just by keeping your account open with a balance of $10 or more. ★ Come and open your account now—or write to us and save-by-mail!

ACCOUNTS INSURED UP TO $15,000
BY AN AGENCY OF THE U. S. GOV'T.

American National
BUILDING & LOAN ASSN.
LEXINGTON AND LIBERTY STS., BALTIMORE
TOWSON PLAZA • PERRY HALL • FALLSTAFF
HARUNDALE MALL • WESTVIEW

Funds Received by 10th of the Month Earn Dividends for the Entire Month

INSURED

FEDERAL HOME LOAN BANK SYSTEM MEMBER

Accounts Insured up to $15,000 by an Agency of the U.S. Government

Pay 'Phone or Gas & Electric Bills at Any Office.
Money Orders and Travelers' Checks Available

AMA Concern About Physician Supply Dates Back 50 Years

POLICY: A newspaper reporter asked the president of a state medical society why the American Medical Association had ignored the growing shortage of physicians until a year ago. The prevalence of this notion is hard to understand. The fact is that the AMA's concern with the problem of maintaining an adequate supply of physicians for the health needs of the nation can be traced back for at least half a century. As long ago as 1919, for example, the AMA House of Delegates recognized an increasing demand for physicians and called for improvements in medical education to meet the demand.

Again in 1922, the House of Delegates urged expansion of medical schools, construction of new schools and increased financial support of medical education, noting that "the tendency of medical colleges to limit their enrollments is causing some anxiety lest well-qualified students will be unable to secure admission to acceptable medical colleges."

In 1951 the House of Delegates stated that the AMA "has no desire to limit the production of properly trained physicians to serve the American people. The policy of the Association is to assist and encourage any responsible group or institution endeavoring to create new facilities or expand existing facilities for the training of physicians. . . . The Association does not attempt to regulate the size of the national student body in medicine. The number of students admitted . . . is determined by . . . each school, in accordance with the school's educational philosophy and its own judgment of its educational resources."

Only once in the last 50 years has the AMA suggested that the medical profession was overcrowded. That was in 1933 in the midst of the Depression.

But for the last quarter of a century the policy of the AMA has been that more physicians were needed. This policy has been reflected in pronouncements by the House of Delegates and the

Council on Medical Education and in statements by AMA officers. Just ten years ago the AMA again was urging medical schools to expand enrollments and to relax geographical restrictions on admission of new students.

In the past two years, the shortage of physicians has become increasingly more critical because the demand for health services has risen faster than the increase in facilities and personnel. There are several reasons. The American people are more knowledgeable about medicine, its progress and its benefits. They request more services because they know their value. They also are increasingly more affluent and they are willing and able to spend more on their health. The phenomenal growth of health insurance, easing the financial burden of illness and injury, has influenced the increase in demand. The U. S. population is rising and demand rises with it. A multitude of federal health programs have suddenly poured billions of dollars into an already overstrained health care system, increasing the demand and compounding the manpower problem. The number of physicians in government service has also contributed to the problem. More than 26,000 physicians, exceeding the total number of physicians taking care of patients in 23 of our states, are now in government service.

The charge that the AMA has ignored the problem is wholly unwarranted. The long-standing policy position that more physicians are needed has been translated into positive programs.

ACTIVITY: Seventeen years ago, the AMA recognized that many more medical schools would be needed quickly and began urging Congress to enact a program of federal grants for medical school construction and expansion. A dozen years elapsed, however, before the legislation was enacted. More recently, the AMA has endorsed the use of federal funds for aid in medical school operations.

Seeking to increase the supply of physicians, the AMA has also:

1. Conducted an extensive, continuing, nationwide careers program to attract more young men and women into careers in medicine or in allied health professions or occupations.
2. Inaugurated a loan guarantee program in 1962 to help students, interns and residents finance their education and training.

• ART SERVICES
• COMPOSITION
• OFFSET & LETTERPRESS
• ROTARY
• FLEXOGRAPHIC
• PAMPHLET & BOOKBINDING
• MAILING

THE EVANGELICAL PRESS
THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"

RUG CLEANING
Of the Highest Quality at Reasonable Prices
ORIENTAL & DOMESTIC
• Repairing • Storing
• Installing • Moth-proofing
Expert Oriental Rug Repairing & Reweaving
SPECIALISTS IN CLEANING WALL-TO-WALL CARPETS AND FURNITURE IN YOUR HOME
A large selection of Antique and Modern Oriental Rugs and Carpets Available
EST. 1922
Hanna IMPORTER
HOpkins 7-6600
2015 W. 41st ST.
Baltimore, Md. 21211

3. Called for creation of a national commission to properly balance government requirements for physicians against the needs of the public.
4. Participated in the planning and development of the 16 new medical schools which have been built since 1947 and the 10 others that will open by 1971.
5. Appointed a Committee on Health Manpower to study the entire problem of allocation of health resources and to develop constructive, workable solutions.
6. Recently joined with the Association of American Medical Colleges in an urgent program to increase enrollments in the nation's medical schools. The objective is expansion of enrollments to a level permitting all qualified applicants to be admitted.

In addition, the nation's physicians in the last 15 years have contributed almost $68,000,000 to U. S. medical schools, either directly or through the AMA Education and Research Foundation.

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION

ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE

DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily

Tuesday Evenings 7 to 9

355-9300

PATAPSCO AVENUE & FOURTH STREET

Baltimore, Maryland, 21225

DIARRHEA

TROCINATE®

BRAND THIPHENAMIL HCl

The first 400 mg. Trocinate tablet usually relieves discomfort so promptly that Diarrhea ceases to be a bother

Trocinate has no known therapeutic value other than relaxing smooth muscle by direct action when coming in contact with the spastic muscle cell. Trocinate has none of the troublesome side-effects of anticholinergic drugs. Trocinate relieves the discomfort of diarrhea by decreasing both peristalsis and muscle tone. Trocinate is metabolized by the body and eliminated in the urine as harmless degradation products. Normal intestinal function is resumed.

The action of Trocinate is prompt, making the spacing of dosage easy. Often one or two 400 mg. tablets are sufficient to control diarrhea. The recommended dosage in spasm of the G. I. and G. U. tract is 400 mg. q. 4 h. A prescription of twelve (12) 400 mg. tablets will, in most cases, allow the patient to have a few to keep in reserve.

Literature and samples available

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217

Manufacturers of ethical pharmaceuticals since 1856

TROCINATE®

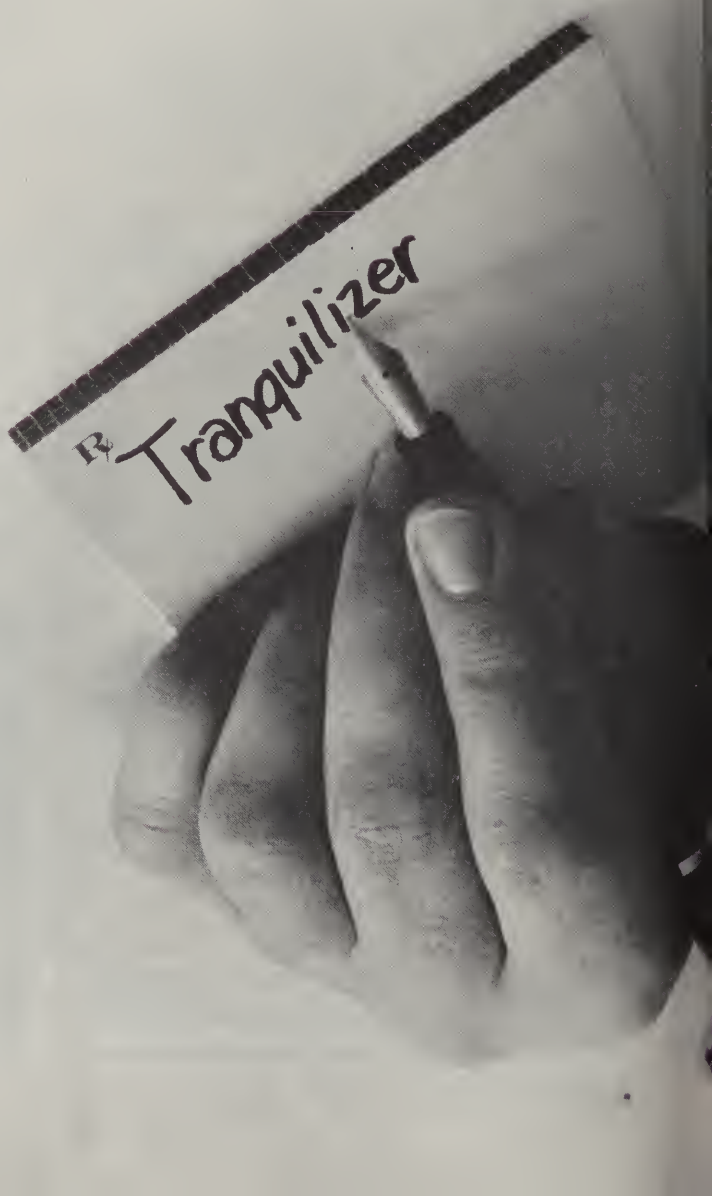
BRAND THIPHENAMIL HCl

DIARRHEA

Pertofrane®, desipramine hydrochloride
Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for

You decide who needs how much

PRESCRIPT



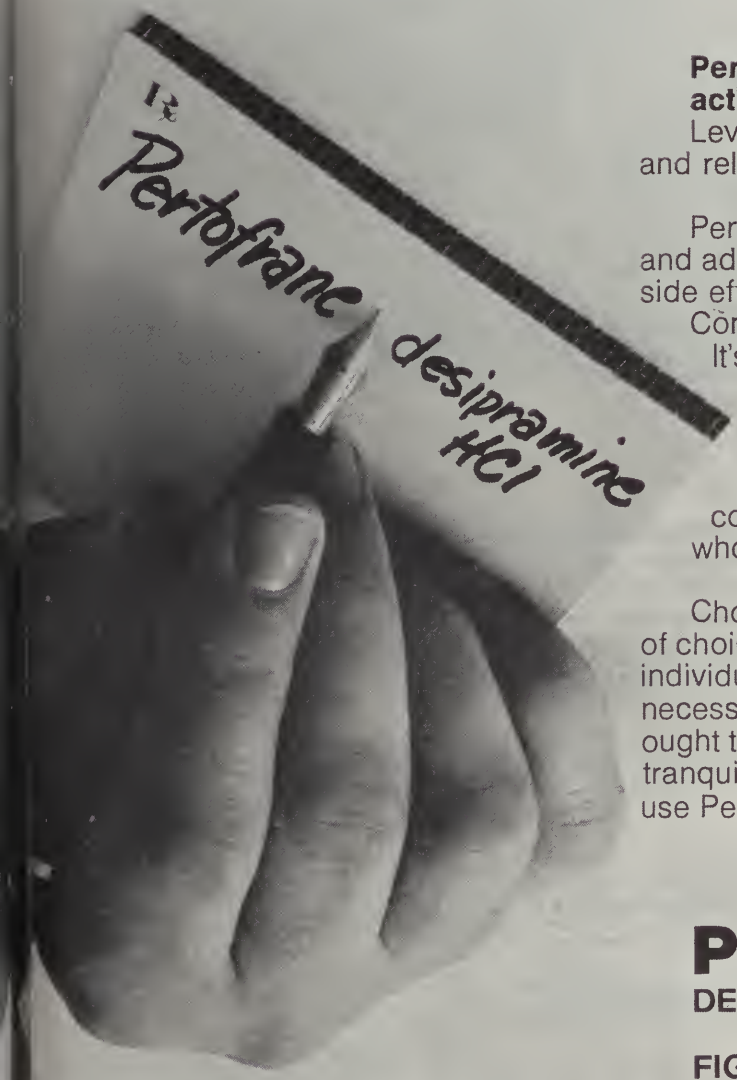
treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000.
(B) 46-530-E

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

antidepressant and how much tranquilizer—

ON POWER



Pertofrane can give rapid antidepressant action often within 3 to 5 days.
Levels of psychomotor activity, patient outlook and related somatic complaints may improve.

Pertofrane is well tolerated by most patients and adverse reactions are usually mild. A few serious side effects have been reported infrequently. Consult full prescribing information before using. It's summarized above.

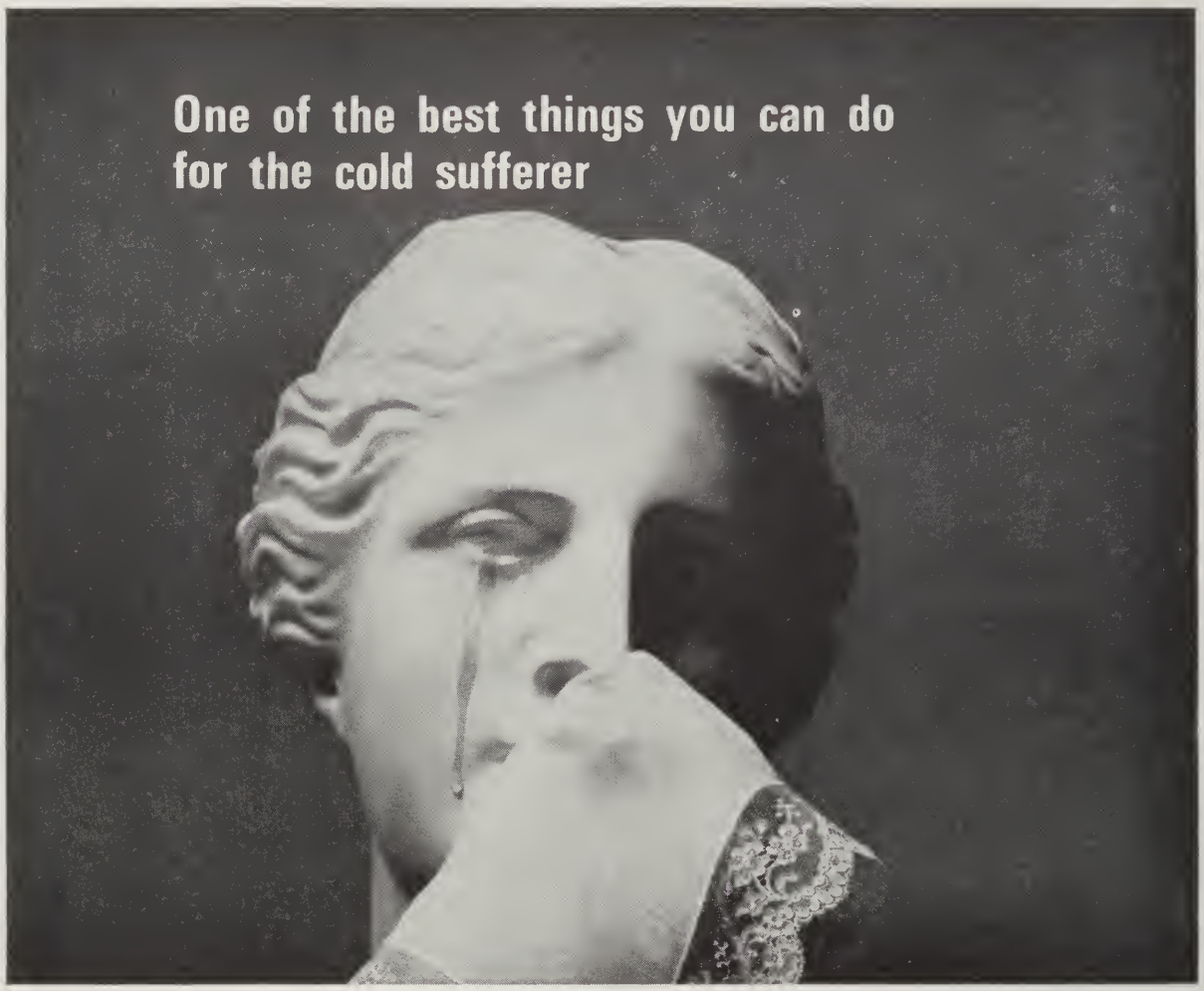
Anxious Depressives...
May require adjunctive use of tranquilizers; but they don't always fit ready-made drug combinations. Isn't it better for *you* to decide who needs how much of which drugs?

Choose Pertofrane and pick your tranquilizer of choice. With this "combination", control the individual drug dosage adjustments that may be necessary for proper therapy. Isn't that the way it ought to be? Please remember, phenothiazine tranquilizers may aggravate depression, and never use Pertofrane with an MAO inhibitor.

PERTOFRANE®
DESIPRAMINE HYDROCHLORIDE

Geigy

FIGHTS DEPRESSION



Ornade®

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage in Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

Ornade® Trademark Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Spansule® capsules

brand of sustained release capsules

Smith Kline & French Laboratories SK&F

BALTIMORE OXYGEN SUPPLY CO., INC.
OHIO CHEMICAL DISTRIBUTORS
Therapy and Medical Gases
Oxygen Tents
Resuscitators and Apparatus
PHONES: 789-8100 727-4748
Main Office and Plant
LINTHICUM, MARYLAND 21090

MANUEL SCHWARTZ
HEARING REHABILITATION
802 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201
DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION
Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

YOUR HEADQUARTERS FOR
PHOTOGRAPHIC EQUIPMENT
. . . for Medical, Surgical, and Research Applications
Phone LE 9-5763
PHOTOCENTER
23 N. Howard St. Baltimore, Md. 21201

Do Your Patients Need Nursing Service?
Call 889-5666
COBB-WOODS SERVICES
Vera Woods, M. A. Director.
2213 St. Paul St. Baltimore, Md. 21218
Licensed by the State of Md.

Volunteer Physicians for Vietnam

Statement by President Johnson on the Arrival of the 500th Physician Volunteer in South Vietnam. August 12, 1968

Three years ago South Vietnam welcomed the first American physician to volunteer for service in a Vietnamese civilian hospital. He was Dr. Richard E. Perry of St. Petersburg, Fla. This program was designed to relieve the suffering of civilians in a country suffering from a severe shortage of medical manpower.

Today, the 500th physician volunteer arrives in South Vietnam as a member of the American Medical Association's Volunteer Physicians for Vietnam program. Dr. Philip A. Pritel of Vancouver, Wash., is one of seven American doctors arriving today at Saigon's Tan Son Nhut Airport almost on the third anniversary of Dr. Perry's arrival in 1965.

Volunteer Physicians for Vietnam is a response to a plea from the South Vietnamese Government and people for medical aid. Supported by funds from the U. S. Agency for International Development, it is administered by the American Medical Association.

Physician volunteers serve 2 months without pay in Vietnamese civilian hospitals.

Physician volunteers have come from 49 States, the District of Columbia, the Canal Zone, and seven overseas posts. Fourteen women have served. Twenty-five doctors have served two tours, and five have served three times in this program. Twelve volunteers have returned to Vietnam as long-term employees to support the U. S. Medical Mission. Two former volunteers are preparing to return to Vietnam as medical missionaries.

Recruitment continues as the need in Vietnam continues; 32 physicians are needed every 60 days to maintain the program at its current strength.

The unselfish example demonstrated by these doctors makes us all proud of our American heritage of aiding the oppressed.

We lease car,

not cars (plural). Car (singular). When a professional man like you wants just one car.

We do one-car-at-a-time leasing with plans particularly appropriate for the professional man. Plans designed to give you the same advantages as enjoyed by big companies that lease.

These advantages include: the new '69 you want as you want it, no capital tied down in a depreciating asset, no separate maintenance or insurance bills, convenient service without extra charge at thousands of "Happy Motoring"® stations throughout the United States, exact transportation costs records on a single monthly bill for tax accounting, no trade-in problems or losses.

Many physicians and surgeons are now leasing. With good reason. Ask your nurse or secretary to drop us a note, or call us, for a detailed booklet explaining the Humble Leasing Plan.

HUMBLE LEASING COMPANY
457 Central Avenue
Newark, New Jersey 07107
Telephone: (301) 837-4510



Dead for an Hour,

Animals that have been "dead" for an hour are being returned to life in the hyperbaric oxygen chamber in a remarkable series of experiments conducted by three medical students, Charles McCluggage, Terry Quinn, and George Brown, under the direction of R. Adams Cowley, MD.

The team worked under the direction of Mr. McCluggage, who began the project with Donald Rice the previous summer.

The new procedure combines cooling, or hypothermia, with high pressure oxygenation. If it can be perfected for use in man it may offer an alternative to the heart-lung machine, which is used in most open heart operations and the more recent heart transplants.

Mr. McCluggage explains that pumping blood through such foreign bodies as the plastic tubing of a heart-lung machine almost inevitably damages blood cells, particularly in small children. The objective was to explore the effects of stopping circulation completely for a one-hour period in order to eliminate the need for shunting blood outside the body.

According to older criteria, stoping heartbeat and arresting circulation for four minutes would have meant the animal's death. But modern criteria of death include consideration of the brain's activity, in addition to that of the heart and lungs. In these experiments, supplying oxygen to the animal's tissues in the high pressure chamber protected the brain and other vital organs from damage. When the heart started beating again "death" lost its finality and became reversible.

"Oxygen requirements are reduced by one-third in our experiments just by cooling the animal to 77° F.," Mr. McCluggage said. "Cooling alone permits us to stop the animal's heart for about 15 minutes without damage to the brain. In addition, before we stop the heart by electrical shock

Animals Revived

we administer pure oxygen through a respirator to saturate the tissues. With the chamber pressure increased to three atmospheres, we can deliver 18 times the normal amount of oxygen, and this protects the brain for almost an hour.

"Three atmospheres of pressure, incidentally, is equivalent in scuba diving to going down about 66 feet in salt water. We use scuba terminology in the chamber—each treatment is a "dive.' "

Although the value of high pressure oxygen treatment has been well demonstrated in such conditions as gas gangrene, there was little knowledge about its use combined with hypothermia prior to these animal experiments.

"One sidelight of the research was to find how easily the heart can be started in the chamber," Mr. McCluggage said. "Cooling to 77° would ordinarily slow the heart to a stop, but not in the chamber. And most textbooks would say that when the heart is fibrillating at temperatures below 89° it cannot be defibrillated. In the chamber, at three atmospheres' pressure, we found it could be defibrillated easily much below 89°.

"The animals were anesthetized and monitored exactly as human patients would be. Each animal was given intensive care for about 24 hours after resuscitation. My classmates and I have spent many a night in Bressler lab caring for the animals. There was almost complete recovery after an hour's circulatory arrest."

The team looks forward to working in the 56-foot high pressure chamber in the new Shock Trauma Center, which will go into operation in January, 1970. And almost certainly, the knowledge they have gained in these experiments will prove even more useful to the advancement of medicine when more sophisticated equipment is available in the new chamber.

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

F.T.D.

Geo. RADEBAUGH *& Sons*

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300

$14,000 in 1968 Equals $5000 in 1939

A family of four needs $14,000 a year to have the same purchasing power it had in 1939 according to the National Industrial Conference Board. In 1939, a $5000 a year man with 3 dependents had $4,941 to spend after taxes. Today he needs $14,282 to net the same because taxes chipped away $2,083 and inflation $7,258.

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ INGLESIDE SHOPPING CENTER
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ HILLENDALE SHOPPING CENTER
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA
Founded 1904
A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY
Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

CHARLES W. NEVILLE, JR., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—253-2761

Med Students Aid Hard-Core Addicts

Twelve University of Maryland medical students, including ten members of the Student Health Organization, spent their summer days working with hard-core drug addicts in a rehabilitation program called Man Alive. This program offers treatment through the drug Methadone and through group therapy.

Methadone treatment has raised considerable controversy, since it too is habit forming, and many doctors feel that it merely substitutes dependence on one drug for another. Its advantage, however, is that it kills the craving for harder drugs and blocks their euphoric effects.

The Baltimore center at Mosher and Penn streets is one of three is the country that offers Methadone. There is another one on Belair Road and one in New York City.

The medical students, who had all received summer fellowships in psychiatry, led the therapy sesions. Robert Derbyshire, MD, supervised.

The idea for student participation in the project was sparked by SHO chairman Jerry Kay, a sophomore medical student. Mr. Kay feels that Methadone treatment and group therapy are much more successful than conventional treatment methods, ie, those offered by the federal government.

"We were all impressed with the intelligence and expressiveness of the addicts in the therapy sessions.

"I think that the medical community should be more aware of the narcotics problem. We often encounter hostility from doctors, and from law and federal officials who disapprove of Methadone."

Based on the success of the program on Mosher Street, SHO members are helping to set up therapy sessions at the Man Alive Center on Belair Road.

when treatment requires

MOIST HEAT

for the relief of pain



Suggest the Battle Creek

THERMOPHORE

Arthritis? Rheumatism? Aches from Flu, Colds, Sore Muscles? Enjoy oh-so-soothing **relief!** Apply pain-relieving **moist heat** with a wonderful Battle Creek **Thermophore.**
Easy to use. Just "snap the switch." Gives relaxing pain-soothing moist heat in seconds! Use no water. No Messy "wet packs." You've never felt help like this!

Phone for Free Descriptive Literature, or See It At . . .

THERAPEUTIC APPLIANCES, INC.

JULES MORSTEIN

1114 Light St. **Phone 752-6996**

Baltimore Md. 21230

Tuberculosis? Influenza?
Pneumonia? Leukemia?
Hodgkin's Disease? Syphilis?
Systemic Fungal Diseases?
Chronic Chest Diseases?
or

HISTO?

(Histoplasmosis—"The Masquerader")



A new aid in differential diagnosis

HISTOPLASMIN, TINE TEST
(Rosenthal)

The LEDERTINE™ Applicator with the Blue Handle

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle

Ask your representative for details or write Medical Advisory Dept., Lederle Laboratories, Pearl River, New York 10965. 406-8

Classified Advertising

POSITIONS AVAILABLE

PHYSICIALS WANTED—Two general surgeons and one internist for two-year overseas assignment. Board certified, over 35, salary and related benefits. One surgeon required for service in Caribbean area available immediately; surgeon and internist for Afghanistan July 1969. Interested parties contact MEDICO a Service of CARE 660 First Ave., New York, N.Y. 10016. Phone: (212) 686-3110.

FELLOWSHIP TRAINING PROGRAMS—Applications are being accepted for training in comprehensive (psychosomatic) medicine in the Departments of Medicine and Psychiatry at the Sinai Hospital of Baltimore, a 500-bed community general hospital ,closely affiliated with The Johns Hopkins Hospital and School of Medicine. Program is based on a 34-bed medical ward service with clinical responsibility and close supervision by staff psychiatrists and internists. Stipends paying $10-12,000 a year are available through USPHS. Contact: Bernard R. Shochet, MD, Liaison Service, Sinai Hospital of Baltimore, Belvedere & Greenspring Aves., Balto., Md. 21215.

PHYSICIANS—Psychiatrist and orthopedist wanted for part-time employment. Purpose to perform examinations of Armed Forces applicants at Armed Forces Examining and Entrance Station, Fort Holabird. Interested parties call: Dr. M. Borushok, 527-6187.

GENERAL PRACTITIONER—Needs evening office coverage, 2 sessions a week. Monthly salary $400. Pref. fellow or resident in Int. Med. License. Location: Baltimore County. Write: Box #3, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

GENERAL PRACTITIONER WANTED—For vacation relief, 2-4 weeks April, May or June. Western Maryland area. Salary. Home provided. Send resume to: Box #4, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

ADMINISTRATIVE SENIOR MEDICAL HOUSE OFFICER—Responsible for supervising Medical Interns. No night duty. References and personal interview required. Salary open, depending on qualifications. Position available July 1, 1969 or sooner. Apply: Director of Medical Education, Franklin Square Hospital, Balto., Md. 21223.

PHYSICIAN—To provide House Officer type services to pediatric patients in a newly built pediatric unit. Requires availability on a Monday through Friday basis as well as shared on-call duty for nights and weekends. Send resume and related material to: Mr. Stewart B. Crawford, Administrator, Maryland General Hospital, Balto., Md. 21201.

POSITION WANTED

PSYCHOLOGIST (PhD)—20-years exp. in testing and individual, group and family therapy. Interested in joining established psychiatrist in full or part-time private practice, in Montgomery or Prince Georges Counties. Write: Box #5, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201, or call: 384-9059 (Silver Spring).

FOR SALE

GP'S OFFICE FURNITURE & EQUIPMENT—From well-equipped office—waiting room, 2 treatment rooms, consultation room, lab. Also, Sandborn EKG and ultrasonic machine, small autoclave, and miscellaneous instruments. Call: AP 7-1500 (Hyattsville).

GENERAL PRACTICE OR EXCLUSIVE PEDIATRICS—Home-office, new brick split-level. Home: 4 bedrooms, 2½ baths, clubroom, log-burning fireplace, all electric. Office: 3 examining rooms, consultation room, fully equipped lab. New Hospital 3 blocks from office. Well-established practice. Good hunting, fishing, water sports. Offered for quick sale at only $58,000. Contact: Richard F. Tyson, MD, Easton, Md. Phone: (301) 822-2462 Mon., Wed., Sat., or write: R. F. Tyson, MD, 2309 Druid Hill Ave., Balto., Md.

PROFESSIONAL BUILDING, ONE-THIRD INTEREST—Atholton Medical Building, Columbia City, Md. On Route 29. $11,500. For details call: (301) 948-9808.

LENS SET—Reasonable. Call: 833-2707 (Reisterstown).

FOR RENT

SHARE OFFICE SUITE—With established physician in downtown Baltimore professional building. Fully furnished. Available July 1. Call: 764-6729 eves.

TWO DOCTORS' OFFICES—Private street entrances. Alter to suit. Newly renovated building, 805 St. Paul St., Balto. Call: The Suli Co., 752-1532 or 685-2800.

DID YOU KNOW

One out of five hospitalized patients was age 65 or over and accounts for one out of three days spent by patients in hospitals during the first quarter of 1968 reports the Health Insurance Institute. And the American Hospital Association reveals the average cost of care in general hospitals is $61 per day.

MED-CHI ANNUAL MEETING

APRIL 9, 10, 11

For information on the happenings, see pages 12, 13 and 23.

Advertisers in This Issue

Accredited Surgical Sales Co. 32
A & F Nurses Registry 88
Al-Lin Ambulance Service 84
American National Building & Loan Assoc. 107
Arundel Federal Savings & Loan Assoc. 109
Baltimore Federal Savings & Loan Assoc. 29
Baltimore Nurses Exchange, Alice Weber 100
Baltimore Oxygen Supply Co., Inc. 113
Broadview Restaurant 71
Burroughs Wellcome & Co., Inc. 96
Capital Savings & Loan Assoc. 116
Oscar Caplan & Sons 8
Central Dodge, Inc. 30
Club Venus 71
Cobb-Woods Services 113
Cork 'n Bottle Restaurant 71
Herbert Cox—Correct Shoes 24
Dobbs House 71
Doctors Supply Co. 24
Eleven East Chase St. Corp. 106
Equitable Trust Bank 78
Evangelical Press 108
Fedder's Medical Services 8
Federated Business Services, Inc. 103
Fields Pharmacy 88
Franklin Uniform Co. 26
Geigy Pharmaceuticals 34-36, 110-111
Globetrotter Travel Agency 88
Hanna Rug Co. 108
Hecht Co. Northwood Rooftop Restaurant 71
Hidden Brook 84
High Fidelity House 106
Highland Hospital 116
Hilton Nursing Home ..... 3rd Cover
Hobelmann Motors, Inc. 106
Hood Convalescent Home 81
House in the Pines Nursing Homes 102
Humble Leasing Co. 114
Hynson, Westcott & Dunning, Inc. 1
International Pharmaceutical Corp. 14-16
Kelly Pontiac 28
Lakeside Laboratories 41
Lederle Laboratories 3, 93-94, 100-101, 106, 117
Eli Lilly & Co. 4
Lucas Brothers 88
Maico Hearing Aids, Inc. 99
Maria's 300 Restaurant 71
McNeil Laboratories, Inc. 37
Mercantile-Safe Deposit & Trust Co. 33
Miller Bros. Restaurant 71
Milton Inn 71
Monarch Lincoln Mercury, Inc. 99
Murray-Baumgartner Surg. Instr. Co., Inc. 11
National Drug Co. 27, 40
Obetrol Pharmaceuticals 82
Olney Inn 92
Palmer House 71
Parke, Davis & Co. 95
Photocenter 113
Pitman-Moore 76-77
Pleasant Manor Nursing Home 92
Wm. P. Poythress & Co., Inc. 109
T. Rowe Price Growth Stock Fund, Inc. 81
Professional Management Co. 11
Geo. Radebaugh & Sons 115
Read's Drug Stores 116
R & H Motors, Inc. 100
A. H. Robins Co. 19-21, 72
Roche Laboratories ..... 104-105, 4th Cover
Russell, Marsh & Kennedy, Inc. 17
Manuel Schwartz, Hearing Rehab 113
G. D. Searle & Co. 38-39
Skill Surgical, Inc. 102
Smith, Kline & French Laboratories 112
Special Diet Shop 103
Sterling Lighting Co. 88
Stuart 18
Mano Swartz—Furs 8
Taylor Manor Hospital ..... 2nd Cover
Therapeutic Appliances, Inc. 117
Tijuana Tacos 71
Town & Country Motors 98
Van Dyke & Bacon—Shoes 92
D. Stuart Webb Advertising Services, Inc. 100
Westview Lounge & Supper Club 71
White Rice Inn 71
Winthrop Laboratories 73
Wyeth Laboratories 74-75
Zimmermann's Shoes 8

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number, the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.

Opening 1969



HILTON NURSING HOME

3313 Poplar Street, corner of Hilton

4 blocks south of North Ave. & Hilton St.

BALTIMORE

Now being built—a superb new 104-bed facility, the last word in pleasant living and competent care for the aged, ill or convalescent. Embodying the highest standards and the most advanced equipment and luxurious furnishings, it will meet your most exacting requirements.

Modern, air-conditioned and fire-safe building

Finest facilities for comfort and health care

104 beds, all in private and semi-private rooms—no wards or dormitories

Registered nurses 24 hours a day

For advance information . . . . phone

426-3104

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal
(persistent palpitations)



Valium®
(diazepam)

for reliable relief of psychic tension and associated somatic and depressive symptoms (including tension-induced insomnia)... usually well tolerated... 2-mg, 5-mg or 10-mg tablets *t.i.d.* and *h.s.*

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).
Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.
Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

READING ROOM

NATIONAL LIBRARY OF MEDICINE
RECD. APR 9 1969
INDEX
INPUT

Q JTC: LJY
INDEXER:
VOL-ISS: 18-3
DATE:
DEPTH:
NON-DEPTH:
RUSH:
SELECTIVE:



The Faculty Building

Maryland State Medical Journal

OFFICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

VOLUME 18, NUMBER 3
MARCH 1969

BETHESDA MD 20014
9600 ROCKVILLE PIKE

In Honor Of Doctors' Day, March 30, 1969



"In the records of no other profession is there to be found so large a number of men who have combined intellectual pre-eminence with nobility of character."

SIR WILLIAM OSLER

Doctors' Day, honoring the men and women of the medical profession, is observed annually on March 30. This date commemorates one of the greatest milestones in medical history. For on this day, in 1842, Dr. Crawford W. Long first used ether anesthesia in surgery. In 1949, the red carnation was chosen the symbol for Doctors' Day.

In recognition of the doctors' contributions to the people and communities they serve, the Enoch Pratt Free Library is dedicating a window of the Central Library to Doctors' Day from March 25th to April 21st.

Honoring Doctors' Day, a contribution will be made by our Auxiliary to the American Medical Education and Research Foundation, to be divided equally between The Johns Hopkins and the University of Maryland Medical Schools.

Mrs. Karl F. Mech, *President*
Woman's Auxiliary to the
Baltimore City Medical Society

Mrs. John O. Sharrett, *Chairman*
Doctors' Day

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

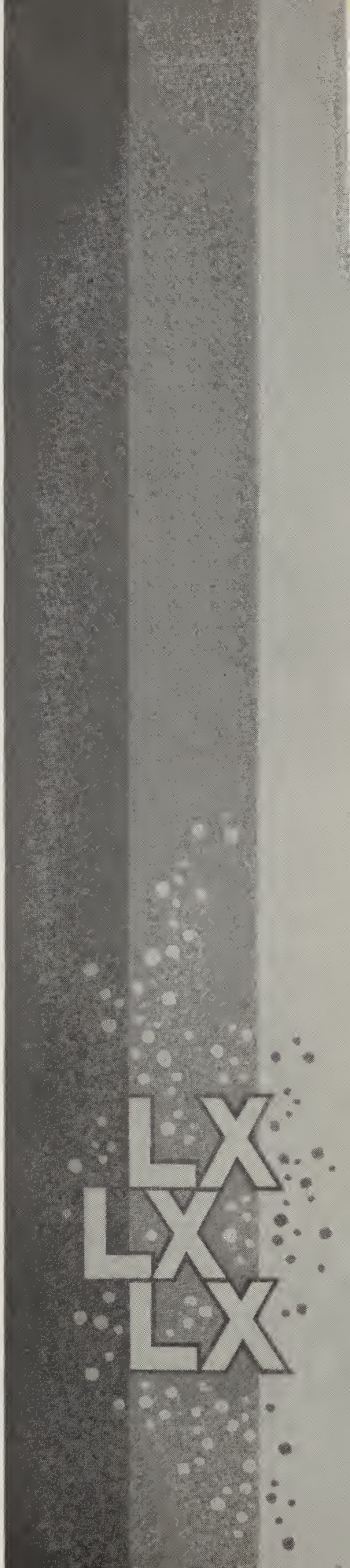
Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

H&D

Baltimore, Maryland 21201

(LX-05)



References:

1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *8*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. 5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes,). J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., \nes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.:)ral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.

Maryland State Medical Journal

VOLUME 18 MARCH 1969 NUMBER 3

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD

E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, MD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

CONTENTS:

The Preceptorship Program of the Maryland Academy of General Practice, Leon W. Berube, MD 52

What's in a Preceptorship?
For the Physician, J. Patrick Jarboe, MD 52
For the Student, John Wilson 53

Alcoholism—Obesity "Sans" Teeth, Merrill I. Berman, MD 56

Alcoholism is NOT a Disease, Ernst Schmidhofer, MD 59

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 65

Rehabilitation Notes—Rehabilitation of Patients with Rheumatoid Arthritis .. 71

Baltimore City Health Department—Baltimore's Health in 1968 83

Heart Page—Recognizing the Acute Coronary Process, Sidney Scherlis, MD 87

Pathology—Community Blood Resource Program 91

Alcoholism Section—Management of Acute Phases of Alcoholism, Including Delirium Tremens, Conference Report, E. G. Beacham, MD 105

Keogh Kwips—Dysfunctions of the Keogh 111

Tuberculosis—Exposure to Cold Environment and Rhinovirus Common Cold 115

Library Page—Medical Librarianship Aids 117

Maryland State Department of Health—Influenza 1968-69 121

Maryland State Department of Mental Hygiene—Is There a Revolving Door? 123

Traffic Safety—Are Your Patient's Eyes Fit for Driving a Car? Solomon E. Barr, MD 125

Doctors Take Note **5** Executive Secretary's Newsletter **9** Book Reviews **16** Annual Meeting Reservation Form **25** Technical Exhibitors **26** Annual Meeting Speakers **27** Annual Meeting Program **29** Component Societies **31** MEDIC **33** Medical News **49** Library Accessions **118** Woman's Auxiliary Annual Meeting Program Preview **127** Ethics Corner **130** Late Meeting Notice **131** Classified Advertising **136** Advertising Index **137** Information For Authors **138**

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland.

Maryland. Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

OFFICERS OF
THE MEDICAL AND CHIRURGICAL SOCIET

President: Arthur G. Siwinski, MD
President elect: Russell S. Fisher, MD
First Vice President: Henry A. Briele, MD
Second Vice President: Wolcott L. Etienne, M
Third Vice President: George O. Eaton, MD
Secretary: William A. Pillsbury, MD
Treasurer: Karl F. Mech, MD

COUNCILORS

Western District

Archie R. Cohen, MD—1969
Henry V. Chase, MD—1969

Central District

Robert C. Kimberly, MD—1969
William Carl Ebeling, MD—1970
John Collins Harvey, MD—1970
John F. Schaefer, MD—1970
William G. Speed, III, MD—1970
J. Arthur Weinberg, MD—1970
John T. Chissell, MD—1971
John M. Dennis, MD—1971
J. Morris Reese, MD—1971
Harry M. Robinson, Jr., MD—1971
Donald J. Roop, MD—1971

Eastern District

Arthur T. Keefe, MD—1970
Raymond M. Yow, MD—1971

Southern District

Manning W. Alden, MD—1969
J. Parran Jarboe, MD—1971

South Central District

William B. Hagan, MD—1969
Henry P. Laughlin, MD—1970
John G. Ball, MD—1971
Wolcott L. Etienne, MD—1971
Seruch T. Kimble, MD—1971

Terms of office expire at conclusion of annual meeting

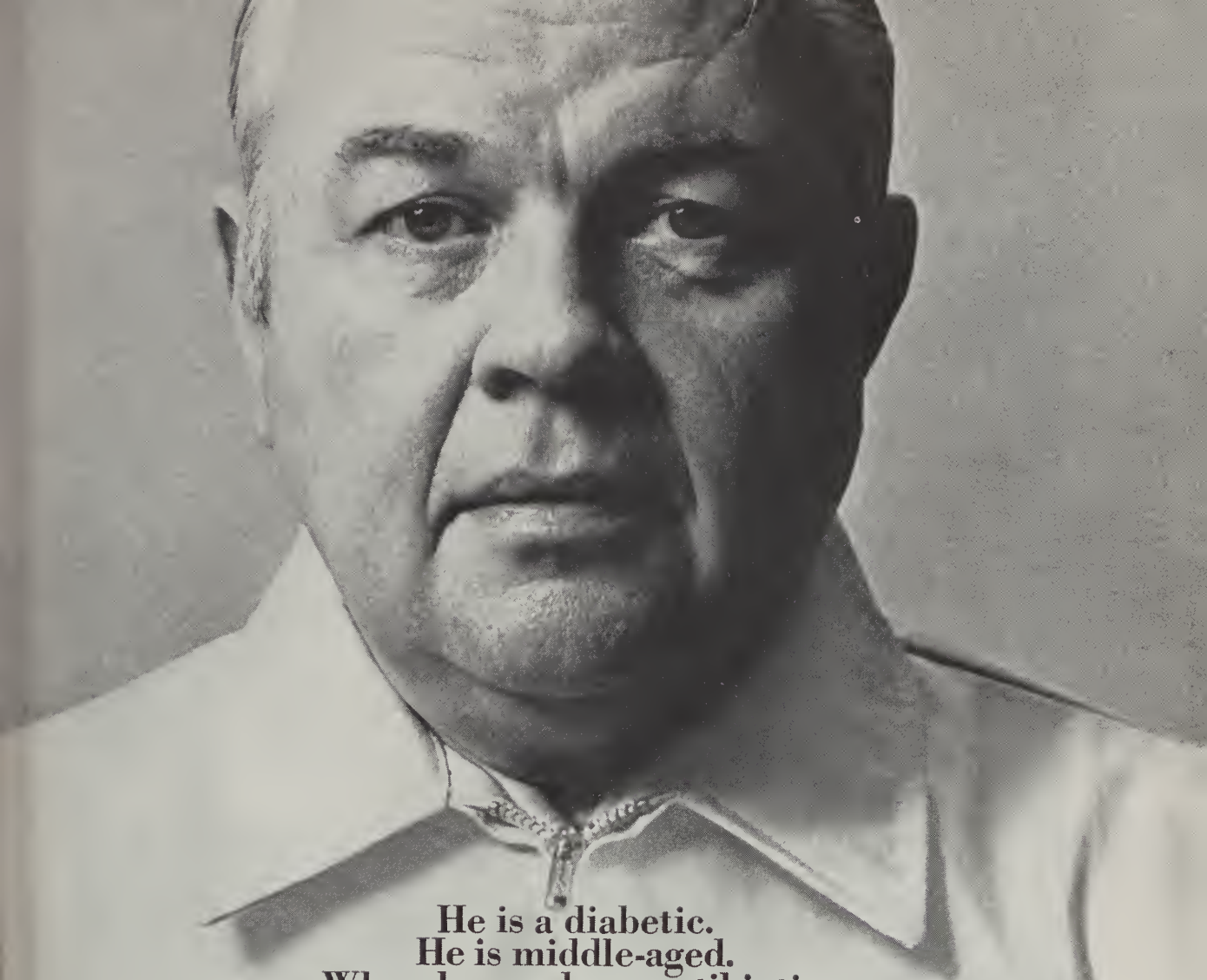
DELEGATES TO THE
AMERICAN MEDICAL ASSOCIATION

Russell S. Fisher, MD—1969
J. Sheldon Eastland, MD—1970
Robert vL. Campbell, MD—1971

ALTERNATES:

M. McKendree Boyer, MD—1969
Robert C. Kimberly—1970
Charles F. O'Donnell, MD—1971

Terms of office expire at end of calendar ar



He is a diabetic.
He is middle-aged.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

) guard susceptible patients against intestinal monilial over-owth during broad-spectrum therapy—the protection of ystatin is combined with demethylchlortetracycline in ECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN the broad-spectrum therapy that prevents monilial ergrowth.

fectiveness: Because its antibacterial component is DECLOMYCIN -methylchlortetracycline, DECLOSTATIN should be equally or more ective therapeutically than other tetracyclines in infections caused by racycline-sensitive organisms. The antifungal component, Nystatin, otects against superinfection by antibiotic-resistant fungal overgrowth articularly monilia) in the intestinal tract.

ntraindication: History of hypersensitivity to demethylchlortetracy-ne or nystatin.

rning: In renal impairment, usual doses may lead to excessive accum-tion and liver toxicity. Under such conditions, lower than usual doses indicated, and, if therapy is prolonged, serum level determinations y be advisable. A photodynamic reaction to natural or artificial sun-ht has been observed. Small amounts of drug and short exposure may oduce an exaggerated sunburn reaction which may range from ery-ma to severe skin manifestations. In a smaller proportion, photo-rgic reactions have been reported. Patients should avoid direct osure to sunlight and discontinue drug at the first evidence of skin comfort. Necessary subsequent courses of treatment with tetracy-es should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

It's almost as if you were there to give an injection of penicillin



V-Cillin K®, Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin® (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K® (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K® (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful). [042567A]

900134

Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206

Lilly

Doctors take note...

MARCH 22-23, 1969
AMERICAN PSYCHIATRIC ASSOCIATION COMMITTEE ON PSYCHIATRY AND MEDICAL PRACTICE

8th Colloquium—Problems and Issues in Communication and Collaboration Between Psychiatrists and Other Physicians: Hilton Hotel, Pittsburgh, Pa. Speakers: Maynard Shapiro, MD, president of the American Academy of General Practice; Frank Kiesler, MD, director of the Northland Mental Health Center; Mr. Harry Henderson, editor of the World Wide Medical News Service. Coordinator: Rex A. Pittenger, MD. Contact: Dr. Pittenger, c/o GP Education Project, 1700 Eighteenth St. N.W., Washington, D.C. 20009.

MARCH 24-28, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Modern Pathology for Internists: University of Pittsburgh School of Medicine and Presbyterian University Hospital, Pittsburgh, Pa. Co-Directors: Robert S. Totten, MD, William Cooper, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 26-28, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Three Days of Gastroenterology: Emory University, Atlanta, Ga. Director: John T. Galambos, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MARCH 28-29, 1969
AMA COUNCIL ON MEDICAL SERVICE AND DIVISION OF HEALTH SERVICE

3rd National Congress on the Socio-Economics of Health Care—Major Issues in Health Care: The Challenge to Medicine: Palmer House, Chicago, Ill. Contact: Council on Medical Service, American Medical Association, 535 N. Dearborn St., Chicago, Ill. 60610.

MARCH 31, 1969
BALTIMORE CITY MEDICAL SOCIETY—SECTION ON INTERNAL MEDICINE/MARYLAND SOCIETY OF INTERNAL MEDICINE

Transplantation—Past, Present and Future: 8:15 PM, Osler Hall, 1211 Cathedral St., Baltimore. Speaker: Albert L. Rubin, MD, Associate Professor of Surgery and Biochemistry, Cornell University Medical College, New York.

MARCH 31-APRIL 2, 1969
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

20th Symposium—Psychiatry and the Internist: Host Farm Resort Motel, Lancaster, Pa. Directors: Paul Jay Fink, MD, Wilbur Oaks, MD. Contact: Sage Cordell, Assistant Director, Continuing Education, Hahnemann Medical College and Hospital, Department of Medicine, 230 N. Broad St., Philadelphia, Pa. 19102.

MARCH 31-APRIL 2, 1969
PHILADELPHIA COUNTY MEDICAL SOCIETY

33rd Annual Postgraduate Institute—Coronary Artery Disease, Recent Advances in Gastro-enterology, Rheumatism, and Medical and Surgical Oncology: Marriott Motor Hotel, Philadelphia. Director: Charles Shuman, MD, Professor of Medicine, Temple University Medical Center. Contact: Philadelphia County Medical Society, 2100 Spring Garden St., Philadelphia, Pa. 19130.

APRIL 1, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISIONOF HYPERTENSION AND RENAL DISEASES

In-Hospital Conference—Calcium and the Kidney: 4 PM, University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. 21201.

APRIL 9, 1969
HEART ASSOCIATION OF NORTHERN VIRGINIA, INC.

12th Annual Joint Cardiac Symposium: Marriott Twin Bridges Motor Hotel, US 1, Washington, D.C. Contact: Mrs. Anna C. Van Sickler, Executive Director, Heart Association of Northern Virginia, Inc., 609 N. Edgewood St., Arlington, Va. 22201.

APRIL 14-15, 1969
NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL

Course for the Practicing Physician—Cardiac Auscultation: New York University Post-Graduate Medical School, 550 First Ave., New York. Directors: J. Scott Butterworth, MD, Edmund H. Reppert, MD. Contact: Office of the Recorder, Room 158MSB, New York University Post-Graduate Medical School, 550 First Ave., New York, N.Y. 10016.

APRIL 15, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conference—Eye Grounds in Hypertension: 4 PM, University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. 21201.

APRIL 21-23, 1969
AMERICAN ACADEMY OF PEDIATRICS

Annual Spring Session: Sheraton-Boston Hotel, Boston. Contact: Department of Public Information, American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill. 60204.

APRIL 23, 1969
MARYLAND KIDNEY FOUNDATION

Seminar in Renal Disease—Chronic Pyelonephritis in its Proper Perspective: 5 PM, University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. Speaker: Robert H. Heptinstall, MD, Professor of Pathology, The Johns Hopkins University School of Medicine.

APRIL 24-25, 1969
NEW YORK UNIVERSITY POST-GRADUATE MEDICAL SCHOOL

Theory and Practice of Contact Lenses: New York University Post-Graduate Medical School, 550 First Ave., New York. Director: Donald A. Fonda, MD. Contact: Office of the Recorder, New York University Post-Graduate Medical School, 550 First Ave., New York, N.Y. 10016.

APRIL 25-26, 1969
MARYLAND RADIOLOGICAL SOCIETY

Annual Meeting: Statler Hilton Inn, Annapolis, Md.

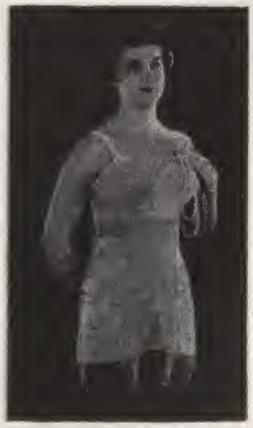
APRIL 26, 1969
TAYLOR MANOR HOSPITAL

2nd Annual Symposium—Manipulating and Controlling Human Behavior by Drugs—Present and Future: Taylor Manor Hospital, Ellicott City, Md. Speakers: Frank J. Ayd, Jr., MD, Editor, *International Drug Therapy* Newsletter; Stanley F. Yolles, MD, Director, National Institute of Mental Health; Henry Brill, MD, Vice Chairman, Narcotic Addiction Control Commission of New York; Nathan S. Kline, MD, Director of Research, Rockland State Hospital, New York; Sidney Cohen, MD, Director, Division of Narcotic Addiction and Drug Abuse, NIMH; Milton Greenblatt, MD, Commissioner of Mental Health, Commonwealth of Massachusetts. Contact: Symposium Coordinator, Taylor Manor Hospital, Ellicott City, Md. 21043. (301) HOward 5-3322.

APRIL 29, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conference—Home Hemodialysis: 4 PM, University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. 21201.

We recommend **CAMP**



SACRO-ILIAC SUPPORTS

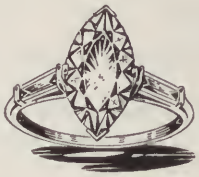
Scientific block and tackle lacings cause the durable Camp material to firmly encircle the bony pelvis, in conservative treatment of sacro-iliac conditions. This basic Camp model also provides upper adjustment to balance the support or to ease spasm and pain, depending on the needs of the wearer. Effective for relief of effects of disease and moderate low back injury.

DONALD O. FEDDER, ORTHOTIST

Rents and Sells
Hospital Equipment

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222



Every Day Is Diamond Day

Birthday, engagement, anniversary, the advent of a new baby—what could be finer than an exquisite diamond to express one's joy?

We can fit a beautiful diamond to whatever price you have in mind.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.



The Label That Leaves No Doubt

Mano Swartz

Maryland's Exclusive Representative for *Oleg Cassini* Furs

Arrange now for safe and dependable fur storage at

Maryland's Oldest and Largest Furrier

225 N. HOWARD ST.
BALTIMORE

executive secretary's newsletter

March, 1969

ADOPTION PROCEDURES

The Faculty office has been contacted in connection with activities on the part of some physicians who have become involved in adoption procedures. Several years ago, legislation was approved that prohibits any individual physician becoming involved in such activities. This law, however, does not apply to Washington and Garrett Counties.

Physicians are urged to utilize the booklet published by the Faculty, "Laws, Rules and Regulations with which Physicians Must Comply." This handy reference pamphlet can avoid many embarrassing situations.

SHEEN AWARD

The American Medical Association has advised the Faculty office to submit the name or names of candidates for the Sheen Award which offers a cash gift of $10,000. Candidates must be American citizens and physicians.

The award was established to honor "An Outstanding American Physician," and is a memorial to Rodman E. Sheen, MD, who died from injuries suffered in a Roentgen Tube explosion.

LAST CALL FOR ANNUAL MEETING

This is the last call for hotel reservations for the Faculty's Annual Meeting. A block of rooms has been reserved at the Belvedere Hotel, where many of the annual meeting functions will take place.

In asking for reservations, please indicate you are attending the Faculty's annual session.

REFERENCE COMMITTEE HEARING

The Reference Committee hearing has been scheduled for:

THURSDAY, MARCH 20, at 8:00 P.M.

in the Faculty building.

Resolutions for consideration at that time include the following:

Resolution 1S/68 - Workmen's Compensation Cases being charged on the basis of "Usual, Customary and Reasonable Fees"; and suggesting a course of action in

REFERENCE COMMITTEE HEARING (cont'd)

this regard.
(Action postponed until the Annual Meeting, 1969)

Resolution 1A/69 - Formation of a Standing Committee to Formulate Model Group Hospital and Medical Insurance Master Policies; and Make its Services Available to Interested Persons; and Urge the AMA Establish a Similar Committee.
(Introduced by Prince George's County Medical Society)

Resolution 2A/69 - Directing that Local Component Medical Societies Establish Policies on a Local Level for Yellow Page Telephone Directory Listings.
(Introduced by Washington County Medical Society)

Resolution 3A/69 - Authentication of House Staff Examinations by Attending or Operating Physician Prior to Major Medical or Surgical Procedures being Performed.
(Introduced by William G. Esmond, MD, and 36 other members)

PERSONALITIES

Gubernatorial appointments include:

William B. Long, MD, Salisbury, named to an additional term on the Board of Regents of the University of Maryland.

J. Sheldon Eastland, MD, Baltimore, to the Medical Board for Occupational Diseases.

Jonas Rappeport, MD, Baltimore, to the Board of the Patuxent Institute.

AMA APPOINTMENTS

William J. Peeples, MD, Baltimore, appointed to the Interspecialty Committee of the AMA.

Paul Q. Peterson, MD, Silver Spring, named as an alternate representative of the AMA on the USPHS Commission on Emergency Medical Services.

John Sargeant
Executive Secretary

YOUR NUMBER MAY BE UP

DOCTOR

◆

IT WILL BE FALSE ECONOMY
NOT TO BE ADEQUATELY
PREPARED

◆

YOUR
INCOME TAX RETURNS

MUST

BE SUPPORTED BY
ADEQUATE RECORDS

◆

OUR SERVICE OFFERS YOU

MAXIMUM CONTROL AND SAFETY
FROM BALANCING RECORDS AND
MINIMUM EFFORT ON YOUR PART

◆

FINANCIAL MANAGEMENT
CAN HELP YOU

◆

DIAL 752-5920

Professional Management Co.

914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN

Featherlite
Contour-Shaped
Surgical Two-Way



SEAMLESS ELASTIC HOSIERY

Now! . . . a new concept in elastic hosiery achieves excellent cosmetic effect and provides the necessary therapeutic qualities of surgical weight. Using a patented inlay method to insure proper lateral support, fine gauge nylon-covered rubber thread is knitted with MAGILOFT (stretch nylon) yarn to produce a lightweight elastic two-way stretch stocking highly resistant to runs and snags.

For the FIRST time in this field, both STOCK and SPECIALS are available; thus you may offer your patients complete selection of elastic two-way stretch stockings with proper compression, regardless of size or shape.

The Contour-Shape, combined with a MAGILOFT SOFT TOP and knitted-in heel, has eliminated wrinkles at ankle and all tendency to slip down at the top.

The SUPPORT of surgical weight is retained with the advantages of light weight, and all the desirable features of fine gage hosiery.

VISIT OUR BOOTH #47
Annual Meeting
Alcazar
April 9, 10, 11, 1969

MURRAY-BAUMGARTNER

SURGICAL INSTRUMENT CO., INC.

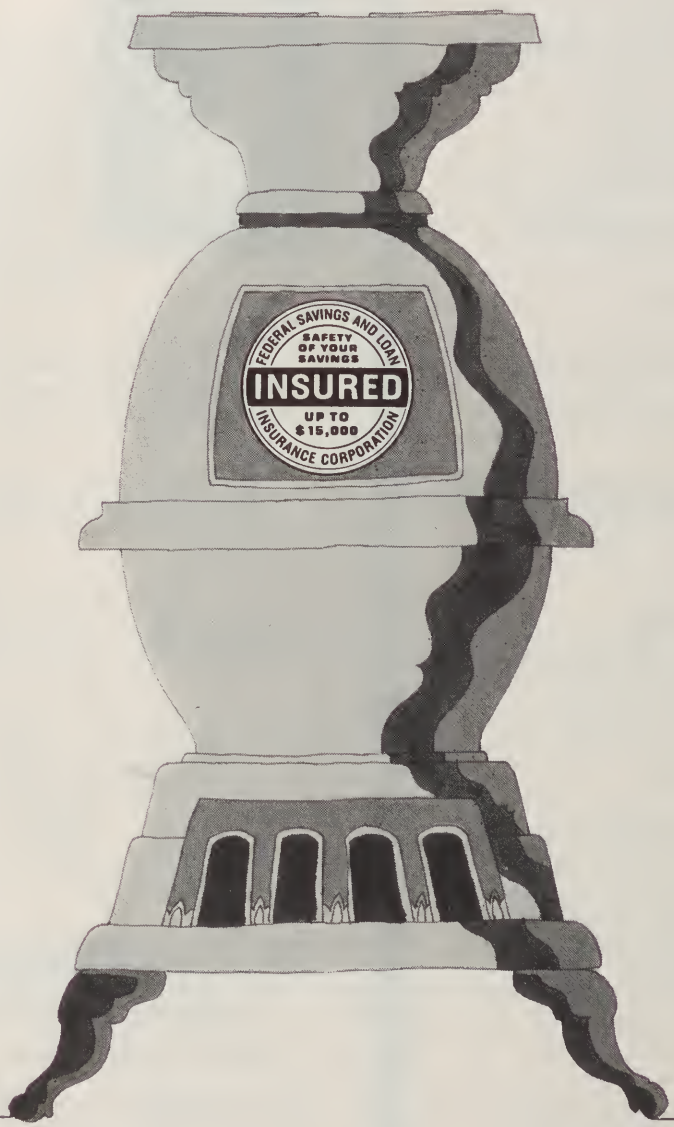
2501 Gwynns Falls Parkway at Warwick Ave.

Phone: 669-9300 **Baltimore, Md. 21216**

Serving the Medical Profession for Almost Half a Century

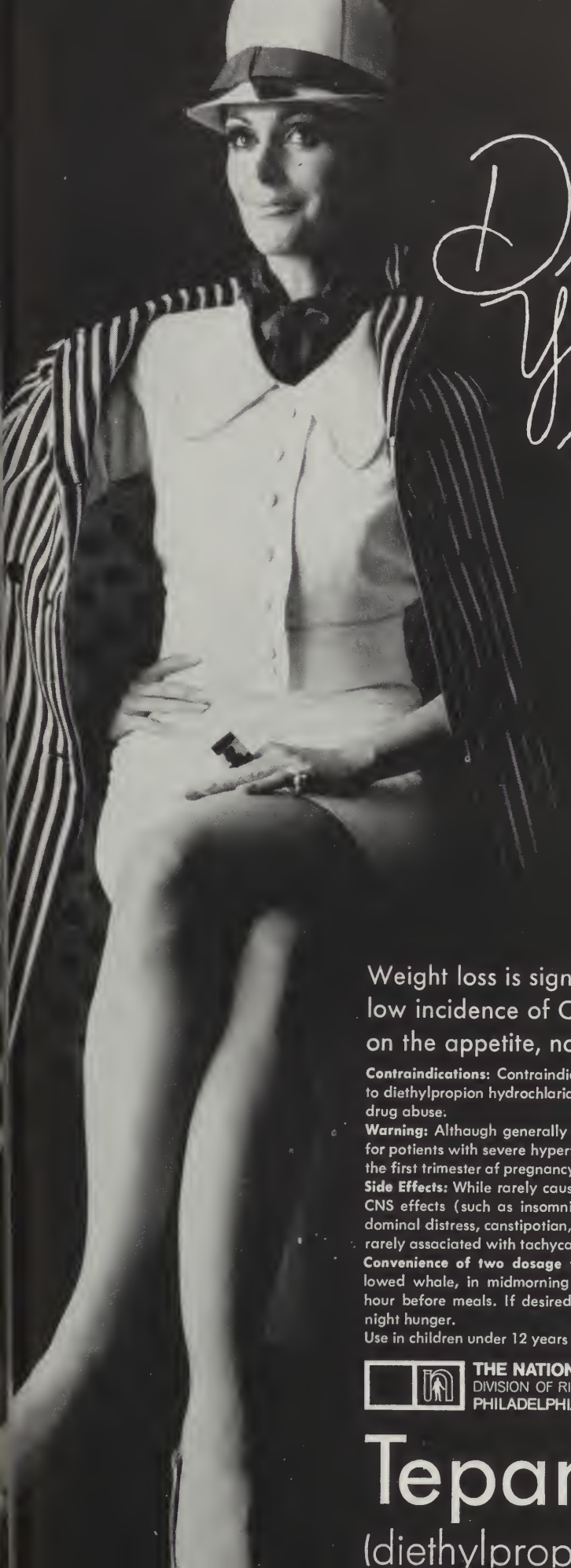
Save at Baltimore Federal

where
quarterly
dividends
give you
that
warm
comfortable
feeling



Open or add to your insured passbook savings account by the 10th and earn Baltimore Federal Savings & Loan Association's extra-high quarterly dividends for the whole month.

Downtown at Fayette & St. Paul Sts. • Eastpoint Shopping Center • Reisterstown Road Plaza
Towson at 7 Alleghany Ave. • Carney at 9609 Harford Road above Joppa • Yorktowne Plaza
Downtown Westminster at 6 East Main Street.



Dear Doctor, You made me what I am today — a whole lot slimmer!

TEPANIL —the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Contraindicoted concurrently with MAO inhibitors, in patients hypersensitive to diethylpropion hydrochlaride, and in emotionolly unstable patients knawn to be susceptible ta drug abuse.

Warning: Althaugh generally sofer than the omphetamines, use greot cautian when prescribing for potients with severe hypertension or severe cardiovascular diseose. Shauld not be used during the first trimester af pregnancy unless potential benefits autweigh potential risks.

Side Effects: While rarely causing theropy to be withdrawn, side effects moy accur occosionally; CNS effects (such as insomnia, nervousness, jitteriness), dryness af mouth, thirst, nausea, abdominal distress, canstipotian, headoche, ollergic respanse including urticario or other dermotitis; rarely assaciated with tachycardia, cordioc arrhythmio or ECG changes.

Convenience of two dosage forms: TEPANIL Ten-tab toblets: One 75 mg. tablet daily, swallowed whale, in midmorning (10 o.m.); TEPANIL: One 25 mg. toblet three times daily, one hour before meals. If desired, on additional tablet may be given in midevening to avercame night hunger.

Use in children under 12 years of age is not recommended.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

So he'll breathe easier:

relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. *And* ease anxiety and tension.

TABLETS

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth®

IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

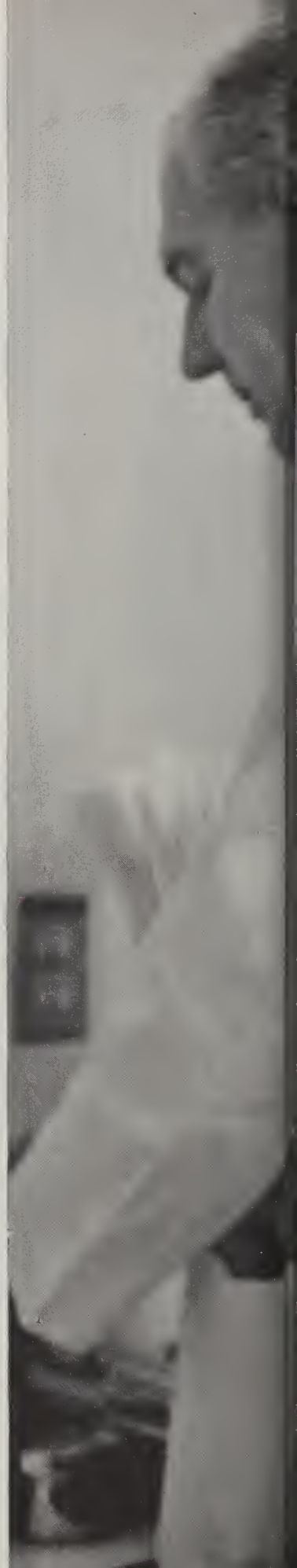
Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

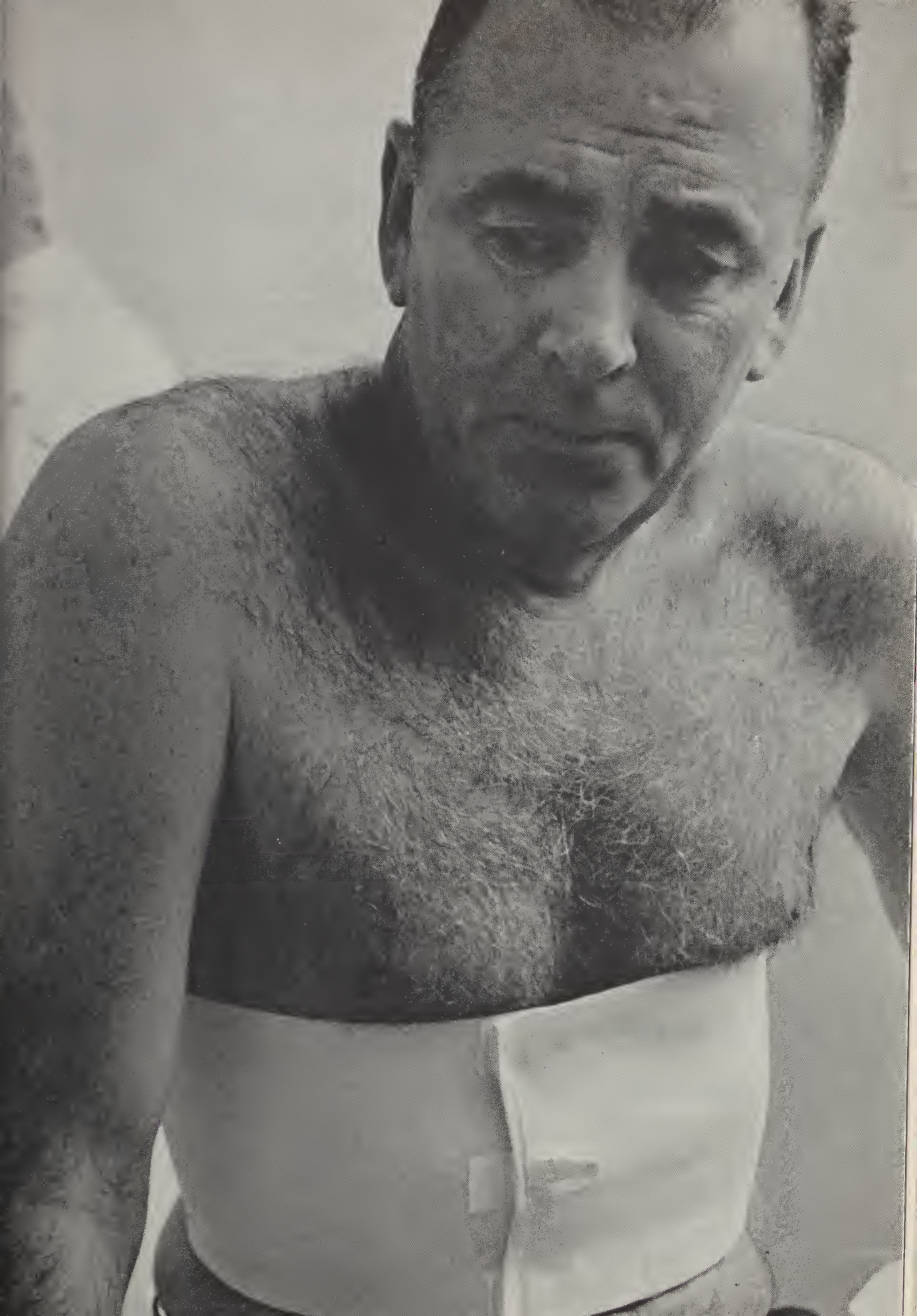
Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





NOW
A NEW CONCEPT
in
BOOKEEPING
and
TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

FEDERATED BUSINESS SERVICES, INC.

Box 580
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager



PRACTICAL PSYCHIATRY FOR THE INTERNIST, Douglas Goldman, MD, and George A. Ulett, MD; The C. V. Mosby Company, St. Louis, Mo. 1968.

The main purpose of this publication is to make the practitioner aware of his own emotional and psychologic functions and the likelihood that he will become involved in the therapeutic interchange with the patient. However, a reasonably smooth transition into the future practice of medicine will require some familiarity at a working level with psychological and emotional aspects of illness, particularly with practical therapy, which must involve interchange (psychotherapy) and application of chemical and physiologic knowledge (psychopharmacology). This volume does well in its presentation of this.

DIAGNOSIS OF SURGICAL DISEASE, Vols I, II, III, Richard T. Shackelford, MD; The W. B. Saunders Co., Philadelphia, 1968.

The author states ". . . I am convinced that most failures of surgical treatment are caused by errors in diagnosis, and that most errors in diagnosis are made because the correct diagnosis simply did not come to mind. . . . For this reason, many disorders which are non-surgical, or belong in the fields of surgical subspecialties, or require no treatment at all, are mentioned so as to remind attending surgeons of their existence."

Dr. Shackelford indicates that the subject matter in the volumes has been arranged according to the usual sequence of events that occur when a patient is first seen by a surgeon. Hence, the first two chapters are on the "time-worn, elementary" subjects of the history and physical examination, but the author's treatment of the rudiments is unique.

All three volumes are combined in a single, well-organized, well-presented bound book. It would be a worthwhile addition to any physician's library whether or not he is involved in surgery or a surgical subspecialty.

THE LANGUAGE OF THE TRANSFERENCE, David W. Shave, MD; Little, Brown & Co., Boston, 1968.

Dr. Shave's book is the result of a two-year study of recorded psychotherapy sessions. It is Vol. 5, No. 2 of the International Psychiatry Clinics series.

"The transference relationship is shown to be a highly dynamic, constantly shifting interaction between the patient and the therapist reflecting, in part, not only the past psychopathological interpersonal relationship of the patient but also the orientation and presentation of the many-faceted ambivalent feelings the patient has toward the different aspects of the therapist as perceived by the patient. . . . "

According to the author, a Maryland psychiatrist, "the purpose of the monograph is not to offer a new type of therapy, but to offer a fundamental theory of a patient's communicative behavior underlying any psychotherapeutic relationship and a recognition of an impressive ego function in working latent content into manifest content. It also offers a method of psychological research completely compatible with past and present analytical theory . . . the goal of the studies . . . is a better understanding of language in any psychotherapeutic endeavor."

WATER AND ELECTROLYTE METABOLISM AND ACID-BASE BALANCE, Edward Muntwyler, PhD; The C. V. Mosby Co., St. Louis, 1968.

This book provides a detailed and simplified treatment of various fundamental principles and examples of practical application in connection with water and electrolyte metabolism. It is an attempt to meet the requests of students for material on water and acid-base balance. It is a clear and concise work which merits a position in a reference library.

SYMPOSIUM ON SURGICAL AND MEDICAL MANAGEMENT OF CONGENITAL ANOMALIES OF THE EYE, from Transactions of the New Orleans Academy of Opthalmology; The C. V. Mosby Co., St. Louis, 1968.

The large attendance at this symposium, devoted to genetically oriented and associated conditions of the eye, prompted the publication of this copy of the transactions of this session. It is well worthwhile to include in any medical library.

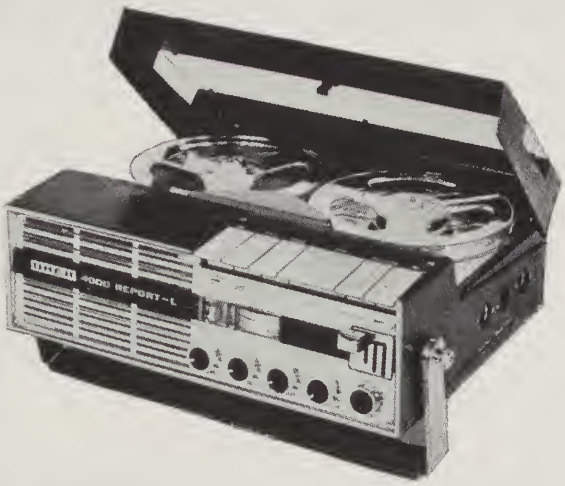
THE NEW UHER 4000-L

Professional Portable Tape Recorder

a

martel

presentation



The UHER 4000-L combines features badly needed by the medical profession, found in no other portable recorder.

FOR LECTURES

Will record up to 8½ hours on one five-inch reel

QUALITY RECORDING AND PLAYBACK

Used by radio stations for interviews and "on the spot recordings"

LISTENING TO MEDICAL TAPES

Can be used in car, home, or office.

A few of the distinctive OPERATING FEATURES of the incomparable UHER 4000-L

Easy operation with brushed aluminum piano-key controls
Three-digit index counter with push-button reset
Fully transistorized and weighs less than 7 lbs.
Picture-window top for improved tape observation

Plus many other outstanding features

CALL US FOR A DEMONSTRATION

"Our Business is Sound"

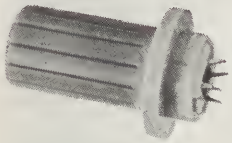
(PARKING IN REAR) BE. 5-4577

BALTIMORE DICTATING MACHINE CO.

3316 GREENMOUNT AVE.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?

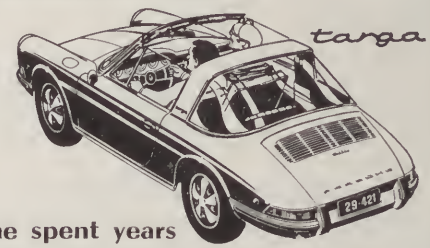


TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.
472-9

PORSCHE



Porsche spent years developing a great competition car so you could have fun driving to work.



Both body styles available in four engines:
912 - 911T
911E - 911S

Sportomatic available on 911 series only

40 West VOLKSWAGEN
Phone: 744-2300
6624 Baltimore National Pike
West of Beltway Exit 15 on Rt. 40 West

A Complete Line of Equipment Used by Most of the Medical Profession

Don't Guess! See an Expert for

Dictating Machine Systems
Recorders (Long Playing)
Video Systems (Sight & Sound Recording)
Cassette & Cartridge Recording & Play-Back Units
Recorders for Lectures & Interviews
Wireless & Remote Control Systems
Office Music Systems

Visit us at the Annual Meeting—Booth 39

"Our Business is Sound"

BE 5-4577

(PARKING IN REAR)

BALTIMORE DICTATING MACHINE CO.
3316 GREENMOUNT AVE.



Traditional Japanese Cuisine

SUKIYAKI TEMPURA
TERIYAKI SUSHI
. . . and others

COCKTAILS AND MIXED DRINKS
SAKE (RICE WINE)
JAPANESE BEER—ASAHI AND KIRIN

11 A.M.—11 P.M.
CLOSED MONDAY

SAKURA PALACE
7926 Georgia Ave., Silver Spring, Md. 20900
JU 7-7070

See next page for prescribing informatio



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specific in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strain may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged actio permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocoliti pruritus ani. Skin—maculopapular and erythematous rashes; a ra case of exfoliative dermatitis has been reported. Photosensitivit onycholysis and discoloration of the nails (rare). Kidney—rise in BU apparently dose-related. Transient increase in urinary output, som times accompanied by thirst (rare). Hypersensitivity reactions—urt caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (ye low-brown) in children of mothers given this drug during the latter h of pregnancy, and in children given the drug during the neonatal pe od, infancy and early childhood. Enamel hypoplasia has been seen i a few children. If adverse reaction or idiosyncrasy occurs, discontinu medication and institute appropriate therapy. Demethylchlortetra cycline may form a stable calcium complex in any bone-forming tissu with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Shoul be given 1 hour before or 2 hours after meals, since absorption i impaired by the concomitant administration of high calcium conte drugs, foods and some dairy products. Treatment of streptococc infections should continue for 10 days, even though symptoms hav subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 30 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

398

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

now she can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).



McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.

If you think the pink pill for U.R.I. symptoms is built for speed and endurance you're on the right track.

lere is a tablet that begins to relieve ymptoms of upper respiratory infec- on quickly—a tablet that works for ours to make it easy for your patient) enjoy continuous relief.

ovahistine Singlet combines effective osage of an antipyretic-analgesic ıth a vasoconstrictor-antihistamine ırmulation to relieve not only the ongestion, but also the fever and e aches and pains that almost always company upper respiratory infections.

A total daily dosage of 3 or 4 tablets will normally provide the continuous relief your patient expects. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine®
Singlet decongestant-analgesic

(Each tablet contains: phenylephrine hydrochloride, 40 mg.; chlorpheniramine maleate, 8 mg.; acetaminophen, 500 mg.)

DOW


New practice?
Heel thyself.
And the best way to do the heeling is with a Professional Loan from Mercantile-Safe Deposit and Trust Company. The Mercantile Professional Loan is especially designed to help you through the financial rough spots of properly outfitting a modern office.
You can get all the details by calling (823-7400) or by writing: Mercantile-Safe Deposit and Trust Company; Professional Department; 409 Washington Avenue; Baltimore, Maryland 21204.
Let "The Merc" heel you quickly. And keep you heeled with a sensible repayment plan.
MERCANTILE-SAFE DEPOSIT and TRUST COMPANY

MAKE YOUR HOTEL ROOM RESERVATIONS NOW

for the

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

APRIL 9, 10, 11, 1969

A block of rooms has been set aside at the BELVEDERE HOTEL, Baltimore, for those attending this meeting. Because of many activities in the city, rooms will be at a premium.

The rates are $19.00 for a double or twin bedded room for two persons; single occupancy rate is $15.00; and suites are $25, $30, and $40.00.

FOR YOUR HOTEL RESERVATION DETACH AND MAIL THIS SLIP DIRECTLY TO:

Mrs. Jacqueline Amati
BELVEDERE HOTEL
Charles & Chase Sts., Balto., Md. 21202

Name .....

Address ..... City ..... State .....

Please reserve ..... rooms Approximate rate ..... No. of persons .....

Date of arrival ..... Date of departure .....

Attending Annual Meeting of the Medical and Chirurgical Faculty.
All requests subject to confirmation.

THE EXHIBITS—A WORTHY FEATURE OF THE EDUCATIONAL PROGRAM

ANNUAL MEETING—APRIL 9, 10, 11, 1969

at the Alcazar

TECHNICAL EXHIBITORS

(as of March 1, 1969)

Abbott Laboratories
American Medical Building Guild, Inc.
Ayerst Laboratories
Baltimore Dictating Machine Company
Bristol Laboratories
Brookes Research Associates
Ciba Pharmaceutical Company
Herbert Cox, Correct Shoes
Doctors Supply Company
Encyclopaedia Britannica, Inc.
Endo Laboratories, Inc.
Equity Funding Corporation
Geigy Pharmaceuticals
Graymar Company
Hummel-Rhode & Co.
Knoll Pharmaceutical Company
Lakeside Laboratories, Inc.
Lederle Laboratories
Eli Lilly and Company
Marion Laboratories
Maryland Blue Cross and Blue Shield Plans
Maryland Medical Political Action Committee
Maryland Pharmaceutical Association
Mead Johnson Laboratories
Med-Chi Insurance Trust
Med-Chi Members Retirement Plan
Medco Products Company
Merck Sharp & Dohme
The Wm. S. Merrell Company
Merrill Lynch, Pierce, Fenner & Smith, Inc.
C. V. Mosby Co. and Yearbook
Murray-Baumgartner Surgical Instrument Co.
Pfizer Laboratories
Physicians Nutritional Services, Inc.
Wm. P. Poythress & Co., Inc.
Program Learning, Inc.
J. B. Roerig Division, Chas. Pfizer & Co., Inc.
William H. Rorer, Inc.
Sandoz Pharmaceuticals
W. B. Saunders Company
G. D. Searle & Co.
Skill Surgical, Inc.
Smith, Miller & Patch, Inc.
E. R. Squibb & Sons
Syntex Laboratories, Inc.
The Upjohn Company
Warner-Chilcott Laboratories
Wyeth Laboratories

Through the courtesy of a contribution from A. H. Robins Company the Medical and Chirurgical Faculty Library will have a booth display.

Hynson, Westcott & Dunning, Inc., has made a contribution, although the company is unable to have an exhibit this year.



The Stenorette® EMBASSY™ . . . the dictating marvel that speeds their work in so many ways

259.50 with Dictating or Transcribing accessories

Discover how this electronic dictating machine can help you do a better job, too, by freeing you from paperwork drudgery. Phone or write today for a free tryout of the low cost EMBASSY.

DeJUR GRUNDIG Stenorette® *EMBASSY™*

When you can't take your secretary with you . . . . .



TAKE OURS

Here's a real traveling secretary for busy doctors —a dictating machine that slips in your pocket and weighs a mere 13 oz. Holds 45 minutes worth of tape in re-usable snap-in cartridge. Talk. Switch. Play-back. Operates on penlite batteries. Complete with case only $69.50.

STENORETTE VERSATILE III



SHE'LL GET THE MESSAGE

Here's the other half of the smallest office dictating-transcribing unit: The Versatile V transcribing unit. Your secretary slips the cartridge into it and . . . she's got the message. Available with stethophose, foot switch, and other extras. Only $99.50 plus accessories.

Visit us at the Annual Meeting—Booth 39

"Our Business is Sound"

BE 5-4577

(PARKING IN REAR)

BALTIMORE DICTATING MACHINE CO.
3316 GREENMOUNT AVE.

171st Annual Meeting

More prominent speakers * who will present papers during the Annual Meeting in April include Burtis E. Montgomery, MD, and Robert H. Johnson, Jr., MD.

At the annual Presidential Banquet on Thursday, April 10, **Burtis E. Montgomery, MD,** Chairman of the Board of Trustees of the American Medical Association, will speak on *New Horizons in Medicine.* This will be the Amos R. Koontz, MD, Memorial Fund Lecture. Dr. Montgomery will speak of some of the things the profession is looking forward to, some of the things that could happen, and what the future holds, particularly for the younger people in medicine.



Dr. Montgomery, of Harrisburg, Illinois, was elected to the American Medical Association's Board of Trustees in June 1966, and was named board chairman in June 1968. He has served as president of both the Illinois State Medical Society and the Southern Illinois Medical Association. Dr. Montgomery is a past member of the board of directors of the National Association of Blue Shield Plans and is at present a member of the board of directors of Blue Shield-Illinois Medical Service. He is a fellow of the International Academy of Medicine, the American Geriatric Society and the American College of Physicians; a member of the American Society of Internal Medicine; and a past member of the Medical Examining Board, Department of Registration and Education, State of Illinois.

A practicing internist, Dr. Montgomery interned at St. Luke's Hospital in Chicago, and did part of his postgraduate work at the Massachusetts General Hospital. He is the holder of cum laude honors from the College of Medicine of the University of Illinois, and in 1967 was named alumnus of the year by that university's Medical Alumni Association. On the lighter side, Dr. Montgomery enjoys two major hobbies—golf and playing the drums.

The I. Ridgeway Trimble Fund Lecture will be given at the Annual Meeting by **Robert H. Johnson, Jr., MD,** whose subject will be *Detection of Head and Neck Cancer.* Dr. Johnson was graduated from Duke University and received his MD degree at the University of Maryland School of Medicine, where he is currently assistant professor of surgery. He served a rotating internship and residency in surgery at the University of Maryland Hospital. In 1960, Dr. Johnson was a clinical associate at the Oak Ridge Institute of Nuclear Study; in 1962 he was a fellow at the MD Anderson Hospital and Tumor Institute in Houston; and from 1965 to 1968 he was senior investigator, surgery branch, National Cancer Institute, National Institutes of Health.



Dr. Johnson is a member of the Society of Head and Neck Surgeons, the Baltimore Academy of Surgery, and the University of Maryland Surgical Society. Included among his many publications are: Complications of Intra-cranial Facial Resection for tumors at the Para-nasal Sinuses; Examination of the Mouth; Surgery in the Role of Treatment of Advanced Oral Pharyngeal Cancer; and Infusion and Radiotherapy for the Treatment of Advanced Cancer of the Head and Neck.

* See the December, January and February Journals for capsule biographies of **Robert L. Evans, MD, Howard W. Jones, Jr., MD, Milton Helpern, MD, Joseph Lee Hollander, MD, Denton A. Cooley, MD,** and **George D. Zuidema, MD,** who also will be featured during the scientific sessions of Annual Meeting in April.

MEDICAL AND CHIRURGICAL FACULTY

OF THE STATE OF MARYLAND

MED-CHI

Members Retirement Plan

TRUSTEE AND ADMINISTRATOR

Mercantile-Safe Deposit and Trust Company

INVESTMENT ADVISOR

T. Rowe Price and Associates, Inc.

LIFE UNDERWRITER

Shenandoah Life Insurance Company

FOR MORE INFORMATION DETACH AND MAIL SLIP DIRECTLY TO:

MED-CHI MEMBERS
RETIREMENT PLAN
1211 Cathedral Street
Baltimore, Maryland 21201

Name .....

Address .....

City ..... State ..... Zip Code .....

Telephone Number ..... Date of Birth .....
(month) (day) (year)

1969 Annual Meeting

MEDICAL AND CHIRURGICAL FACULTY

PROGRAM

All meetings at the Alcazar, Cathedral and Madison Streets, Baltimore, unless otherwise indicated

VEDNESDAY, APRIL 9

1:30 pm OFFICIAL INVESTIGATION OF SUDDEN, SUSPICIOUS AND VIOLENT DEATHS—A COMMUNITY RESPONSIBILITY. **Milton Helpern, MD,** Chief Medical Examiner, City of New York

2:30 pm INTRASYNOVIAL CORTICOSTEROID THERAPY IN ARTHRITIS. **Joseph Lee Hollander, MD,** University of Pennsylvania

3:15 pm OPPORTUNITIES AND PROCEDURES FOR THE EARLY DIAGNOSIS OF CARCINOMA OF THE CERVIX. A panel discussion. **Howard W. Jones, Jr., MD, Hugh J. Davis, MD,** and **John K. Frost, MD,** The Johns Hopkins

4:00 pm DETECTION OF HEAD AND NECK CANCER. **Robert H. Johnson, Jr., MD,** University of Maryland

5:00 pm Hospitality Night for all members and their wives. Belvedere Hotel

8:30 pm Medicolegal Symposium concerning malpractice suits

HURSDAY, APRIL 10

8:30 am MEDICAL GRAND ROUNDS. **Theodore E. Woodward, MD,** and staff, University of Maryland

9:15 am THE PLACE AND FUNCTION OF A COMMUNITY HOSPITAL AS A CENTER FOR GRADUATE AND CONTINUING EDUCATION. **Robert L. Evans, MD,** Director of Medical Education, York (Pennsylvania) Hospital

12:30 pm ROUND TABLE LUNCHEON. Belvedere Hotel

2:30 pm SURGICAL GRAND ROUNDS. **George D. Zuidema, MD,** and staff, The Johns Hopkins

3:15 pm EXPERIENCES WITH CARDIAC TRANSPLANTATION IN MAN. **Denton A. Cooley, MD,** Baylor University

7:15 pm PRESIDENTIAL RECEPTION AND BANQUET. Belvedere Hotel. Music and dancing.
NEW HORIZONS IN MEDICINE. **Burtis E. Montgomery, MD,** Chairman, Board of Trustees, American Medical Association

RIDAY, APRIL 11

8:30 am Coronary Care Panel
PRESENT STATUS AND FUTURE PROJECTIONS. **Leonard Scherlis, MD,** University of Maryland
TREATMENT OF TACHYARRHYTHMIAS. **Kenneth B. Lewis, MD,** Baltimore City Hospitals
TREATMENT OF BRADYARRHYTHMIAS. **Elijah Saunders, MD,** Provident Hospital, Baltimore
ORGANIZATION AND TRAINING NEEDS. **Jerry Salan, MD,** University of Maryland

---

USE OF DELEGATES MEETINGS—Wednesday, April 9, 9:30 am. The Alcazar
Friday, April 11, 2:00 pm. Faculty Building

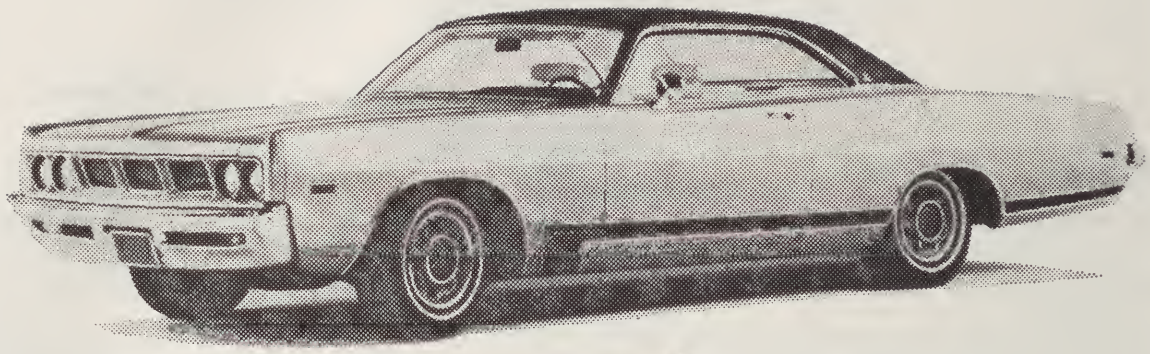
ALTH EVALUATION TESTS—Wednesday, Thursday, Friday. The Alcazar

ENTIFIC AND TECHNICAL EXHIBITS—Wednesday, Thursday, Friday. The Alcazar

No registration fee

A detailed program will be mailed prior to the meeting to all Faculty members and to others upon request

Joseph D. B. King, MD, Chairman
Committee on Program and Arrangements



our
Final Net Figure
figures to
be lower on a
'69 DODGE

CENTRAL DODGE
Baltimore's
Downtown Dodge Dealer
1111 Cathedral Street
Phone 685-3797



P.D.Q. SERVICE ESPECIALLY FOR DOCTORS *Professional, Dependable, Quick Auto Repairs. Our service department has instructions to give precedence to doctors in immediate, accurate electronic diagnosis and prompt, expert therapy on any make car to avoid unnecessary delay in your valuable service to the community.*

COMPONENT SOCIETIES

Baltimore County Medical Association

Theodore Patterson, MD, a general practitioner in the Dundalk area, has been elected president of the Baltimore County Medical Association. Dr. Patterson graduated from the University of Maryland School of Medicine in 1962 and interned at Sinai Hospital in Baltimore. He was assistant resident in medicine at the South Baltimore General Hospital. Dr. Patterson is a member of the American Medical Association, the Medical and Chirurgical Faculty of Maryland, chairman of the Human Relations Council of the Greater Dundalk area, a member of the Baltimore County Senior Citizens Council and a member of the Maryland Academy of General Practice.



Dr. Patterson

The new Vice President of the Association is Wilmer Gallager, Jr., MD, of Catonsville, and the Secretary-Treasurer is John N. Krager, MD, of Towson. The Delegates to the Medical and Chirurgical Faculty House of Delegates are Melvin Davis, MD, Edward Krieg, MD, Gordon Grau, MD, Martin Strobel, MD, Clarence McWilliams, MD, William McGrath, MD, and Charles Williams, MD.

The new address for the Association is 8523 Loch Raven Boulevard where a full-time executive secretary will be located.

Carroll County Medical Society

The Carroll County Medical Society met January 8, 1969 at Hoffman's Inn. Officers for the 1969 term are as follows: President, William R. O'Rourke, MD; President-Elect, John S. Harshey, MD; Secretary, Richard A. Jones, MD; Treasurer, Dean Griffin, MD; One Member-at-Large, Sherman Chang, MD, and Executive Secretary, Nancy B. Jones.

Mr. R. Poole and Mr. A. Weismantel outlined their newly available program for physical therapy at the Carroll County General Hospital.

Mr. Jack Sargeant spoke briefly of various matters of medical interest pending before the Legislature.

Our Society continues to be active in a number of community activities. The most current ones are the Farm Museum Project and the Family Doctor Program. At the Farm Museum Village, we will have a doctor's home and office combination of the 1850 era. Anyone knowing of furniture or equipment that could be used in such an exhibit is asked to contact the Carroll County Medical Society. The Family Doctor Program is broadcast over the local radio station three times weekly and covers topics that are of interest to the entire community.

PHILIP W. MERCER, MD
Journal Representative

Howard County Medical Society

The Howard County Medical Society recently elected officers to the two-year term which began January 1969.

The doctors elected: Peter Van B. Thorpe, MD, president; George Burgtorf, MD, vice-president; Art H. Panayis, MD, secretary; Theodore Shrop, MD, treasurer; and Thomas Herbert, MD, and Justinas Kudirka, MD, delegate and alternate to the Medical and Chirurgical Faculty of Maryland.

Kent County Medical Society

Jorge Oteiza, MD, was elected president of the Kent County Medical Society recently.

John S. Green, MD, was elected secretary-treasurer, and Harry Paul Ross, MD, was chosen as delegate to the Medical and Chirurgical Faculty of Maryland, with Oskar Gulbrandsen, MD, as alternate.

It was announced that Arthur F. Keefe, MD, has been appointed counselor to the Medical and Chirurgical Faculty of Maryland from the Eastern Shore area.

Prince Georges County Medical Society

William R. Greco, MD, of Riverdale, has been elected president of the Prince Georges County Medical Society for the calendar year 1969, succeeding Max M. Herzberg, MD, of Landover.

Other 1969 elected officials include John R. Buell, MD, of Laurel, who replaces Dr. Greco as vice president; S. Jack Sugar, MD, of Riverdale, who succeeds Dr. Buell as secretary; and Leon R. Levitsky, MD, of Mt. Rainier, who succeeds Dr. Sugar as treasurer.

Elected to serve two-year terms on the Society's Executive Board were John T. Lynn, MD, of Marlow Heights and A. Clark Holmes, MD, of Upper Marlboro.

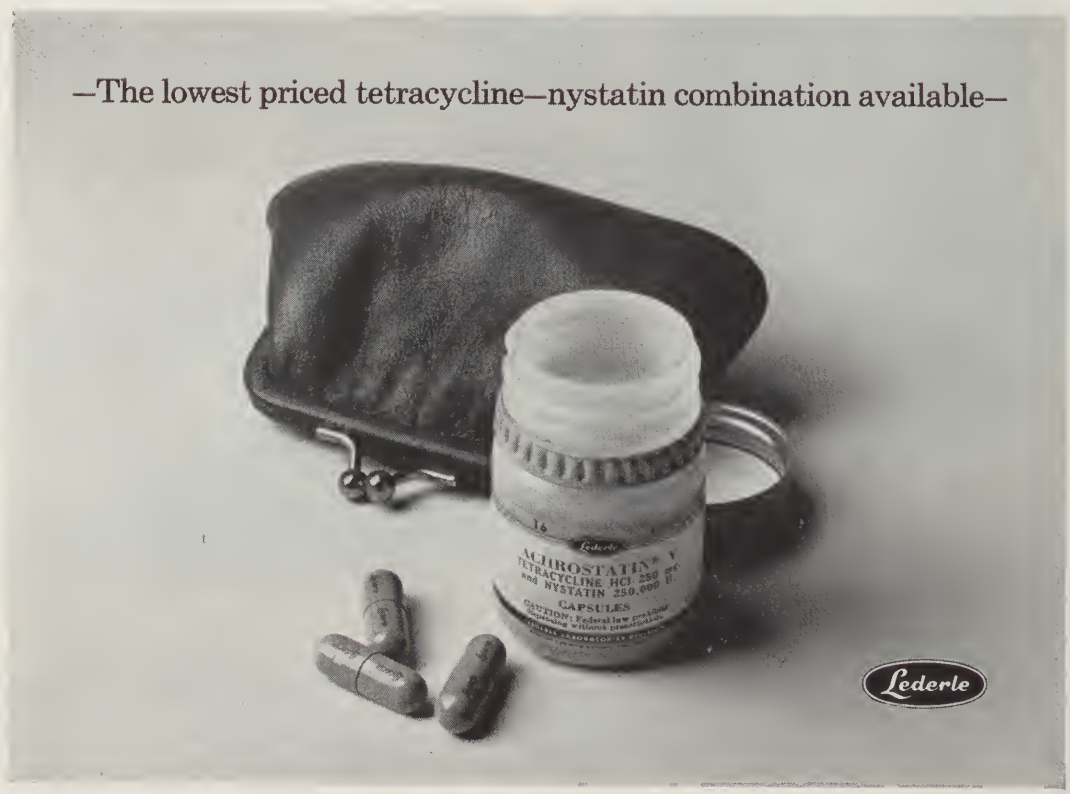
Washington County Medical Society

At the annual meeting in November 1968, John H. Kehne, MD, turned the president's gavel over to Harold H. Gist, MD. Other elected officers are President-Elect E. W. Ditto, III, MD; Vice-President Sidney Novenstein, MD; Secretary R. H. Williams, MD; Treasurer E. B. Moody, MD; Delegates: Sidney Novenstein, MD, J. W. Banks, MD, and A. R. Cohen, MD.

In review, the year went like this. In January, Mr. Charles Greeb, Jr., president of First National Bank of Maryland, spoke of future projections for Washington County, indicating steady growth of the community—augmented somewhat by industrial expansions in adjacent Maryland counties and states.

In March, Dr. Fred Benjamin, chief physiologist with NASA, spoke on medical problems of manned space flight. John J. Dobbie, MD, "a dimunitive dynamo with a wry sense of humor and a great personality," was named Boss of the Year by Hager Chapter, National Secretaries Association at their Annual Executives night. His partner, James W. Banks, MD, was given a lifetime complimentary pass for his healing works

(Continued on page 108)



MEDIC 1969 SCHEDULE

OF POSTGRADUATE PROGRAMS

presented through

Medical Education's Dedicated Instructional Channel

Supported in part by The Medical and Chirurgical Faculty and a grant from Merck, Sharp and Dohme.

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Prince George's General, Cheverly
Provident, Baltimore
Rosewood State, Owings Mills
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
South Baltimore General, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Washington County, Hagerstown

Other Locations:

Medical and Chirurgical Faculty, Baltimore
State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
539-0872

or

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201 383-3010 Ext. 8722

MARCH 28, 1969—12:30 P.M.

CANCER OF THE BREAST

Edward F. Lewison, MD
Assistant Professor of Surgery
The Johns Hopkins University School of Medicine

A review of the historical and epidemiological aspects of breast cancer will be presented. Prompt detection and diagnosis will be discussed. Treatment will be considered from the standpoint of both the operable patient and the inoperable patient with advanced or metastatic disease.

Sponsor: Frederick Memorial Hospital

Replays: Monday, March 31, 1969 12:30 P.M.
Wednesday, April 2, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

APRIL 4, 1969—12:30 P.M.

URINARY TRACT INFECTION

John D. Young, MD
Professor of Urology
University of Maryland School of Medicine

There is increasing evidence that bacteria seldom invade the urinary tract without the help of some contributing factor such as injury to the urothelium or mechanical interference with urine flow. There is experimental evidence that "toxins" from E. coli have an inhibiting effect on ureteral peristalsis which might help perpetrate infection. The diagnosis and treatment of urinary tract infections is discussed with the above principles as a guide. Illustrative X-rays and diagrams will be shown.

Sponsor: Sacred Heart Hospital

Replays: Monday, April 7, 1969 12:30 P.M.
Wednesday, April 9, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

(Continued next page)

APRIL 18, 1969—12:30 P.M.
URINARY INCONTINENCE

Edward W. Campbell, MD
Assistant Professor of Urology
University of Maryland School of Medicine

Urinary incontinence will be considered as a symptom, representing a variety of clinical entities. While commonly a manifestation of local disease affecting the bladder and its supporting structures, incontinence may herald the onset of more distant and serious disease. Differential factors in the historical and physical manifestations of these various etiologic entities will be emphasized. Certain diagnostic procedures and treatment will be discussed.

Sponsor: Maryland General Hospital
Replays: Monday, April 21, 1969 12:30 P.M.
Wednesday, April 23, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

APRIL 25, 1969—12:30 P.M.
MALIGNANCIES OF THE CENTRAL NERVOUS SYSTEM

John A. Wagner, MD
Professor of Neuropathology
University of Maryland School of Medicine

The subject of intracranial tumor is reviewed with appropriate clinical-pathologic correlation. The salient features of the more important primary and secondary tumors is reviewed. Included also are notes on pathogenesis, relation to trauma and present status of research.

Sponsor: Frederick Memorial Hospital
Replays: Monday, April 28, 1969 12:30 P.M.
Wednesday, April 30, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

MAY 2, 1969—12:30 P.M.
CARCINOMA OF THE THYROID

Joseph B. Workman, MD
Associate Professor of Medicine
University of Maryland School of Medicine

Current knowledge concerning the causes, clinical classifications and methods of therapy in thyroid carcinoma will be discussed. Emphasis will be placed on the effect of age at onset, pathologic type, duration of disease and type of therapy upon eventual outcome.

Sponsor: Peninsula General Hospital
Replays: Monday, May 5, 1969 12:30 P.M.
Wednesday, May 7, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

MEDIC 1968-1969 STANDARD WEEKLY PROGRAM SCHEDULE

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8						PEDIATRIC GRAND ROUNDS J.H.H.
9			LECTURE REPLAY			
AM 10						
11						MEDICAL GRAND ROUNDS J.H.H.
11:30		MEDICAL GRAND ROUNDS U. OF M.				
NOON 12						
12:30	LECTURE REPLAY				MEDIC LECTURE	
1						
1:30						
2			LECTURE REPLAY		NEUROLOGY GRAND ROUNDS U. OF M.	
3						
PM 4	PEDIATRIC GRAND ROUNDS - J. H. H.					
5						
6						
7						
8			LECTURE REPLAY			
9						

ALCAZAR SWIMMING POOL
Cathedral & Madison Sts.
Baltimore, Maryland
Phone: 837-8400
Heated Pool *Steam Room*
Our POOL and STEAM ROOM are available to patients who would like to exercise themselves back to Good Health!
Open Mon. thru Fri. *10 A.M. to 3 P.M.*
September thru May
Rates: $15.00 Yearly Membership
Call: Mr. D'Agostino

BLOOD PLAN
of the
METROPOLITAN WASHINGTON BLOOD BANKS, INC.
Not For Profit
A BLOOD DONATION TODAY PROTECTS YOU AND YOUR FAMILY TOMORROW
- A Medically Supervised Blood Benefit Program
- Individual—Family—Group Memberships

T. A. Loosbrock, Exec. Dir.
915 19th St. N.W., Suite 500 Phone 737-0060
Washington, D.C. 20006

BERNHARDT F. PIELKE CLARA S. LANDSCAPE SERVICE

Give your home new beauty with
SKILLFUL LANDSCAPING
TREES, PLANTS, SHRUBBERY
• expertly planned and planted •
FREE ESTIMATES
BELTWAY GARDEN CENTER
7937 Belair Road, Baltimore Md. 21236 NO 8-3965

TOURS ARRANGED TO MEDICAL CONFERENCES AND CONCLAVES
Domestic and International
GLOBETROTTER TRAVEL
A Professional Travel Service
BALTIMORE: REISTERSTOWN ROAD PLAZA • 358-6444
BALTIMORE: MONDOWMIN SHOPPING CENTER 669-8200
WASHINGTON: WHEATON PLAZA SHOPPING CENTER



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm ... tially capsized. The fire departm... had to rescue Waters by small ... Damage to the yacht is estimate...

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A.H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

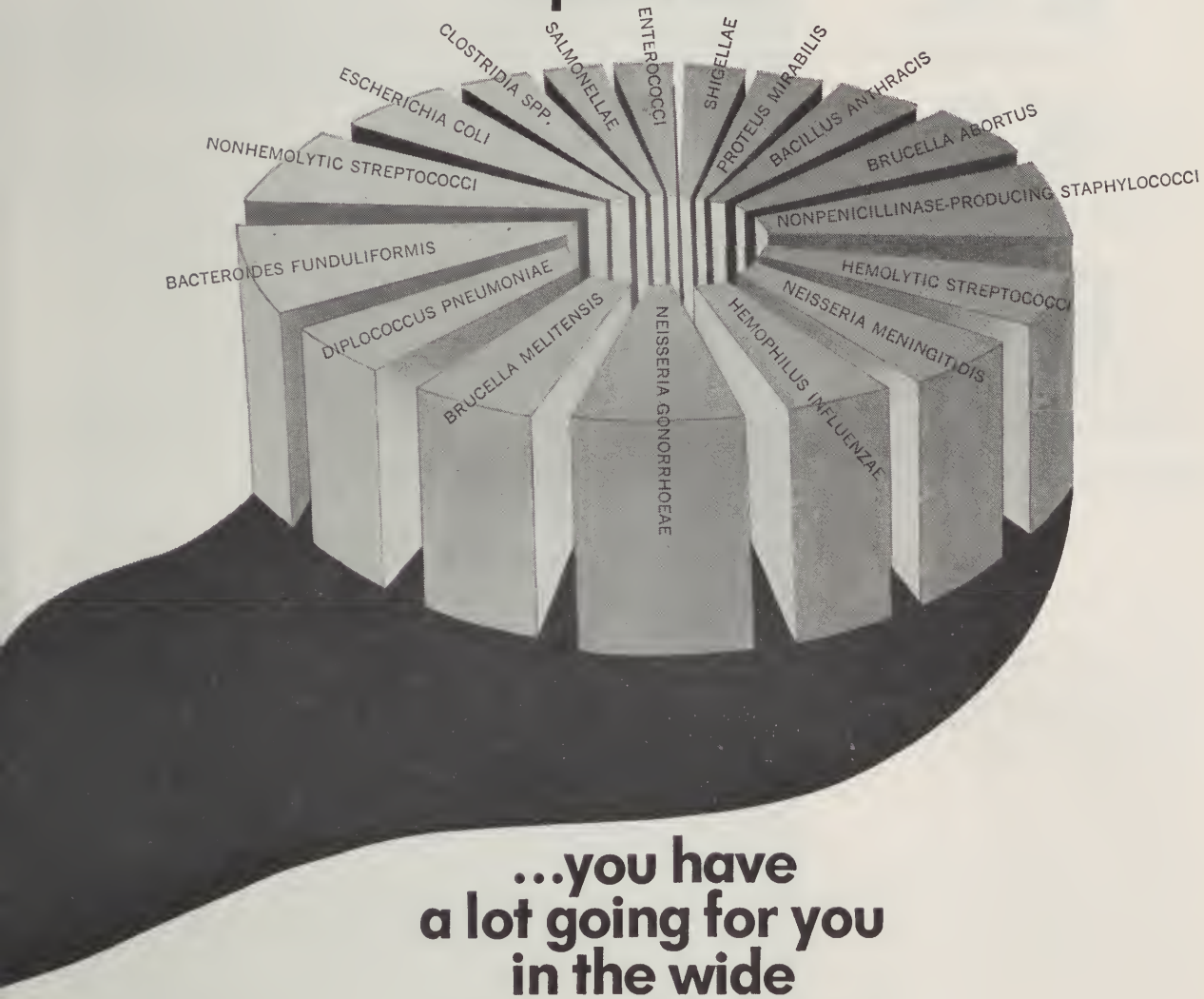
Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. Contraindications: Hypersensitivity to any of the components. Precautions: As with all phenacetin-containing products excessive or prolonged use should be avoided. Side effects: Side effects are uncommon, although nausea, constipation and drowsiness may occur. Dosage: Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. **Indications:** Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci). **Contraindications:** A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms. **Precautions.** Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy. **Adverse Reactions:** Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets. **Usual Dosage:** Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days. **Supplied:** Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

11-1/2/69 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal (persistent palpitations)



ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

B.A. (*cum laude*)...V.P. (at thirty-two)...symbols that illuminate the quality of a life...the satisfactions of achievement, as well as its price...the pressures and stresses that can often create cardiac manifestations of psychic tension. For this kind of patient—with no demonstrable pathology—consider the singular benefits of Valium (diazepam).

With its pronounced calming action, Valium can relieve psychic tension promptly, attenuating its somatic signs and symptoms. Further, Valium is distinctly useful when somatic and depressive symptomatology (secondary to psychic tension) coexist. And Valium is generally well tolerated; in proper maintenance dosage, it seldom dulls the senses or interferes with functioning.

When psychic tension-related insomnia appears, an *h.s.* dose added to the *t.i.d.* schedule helps promote sleep.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

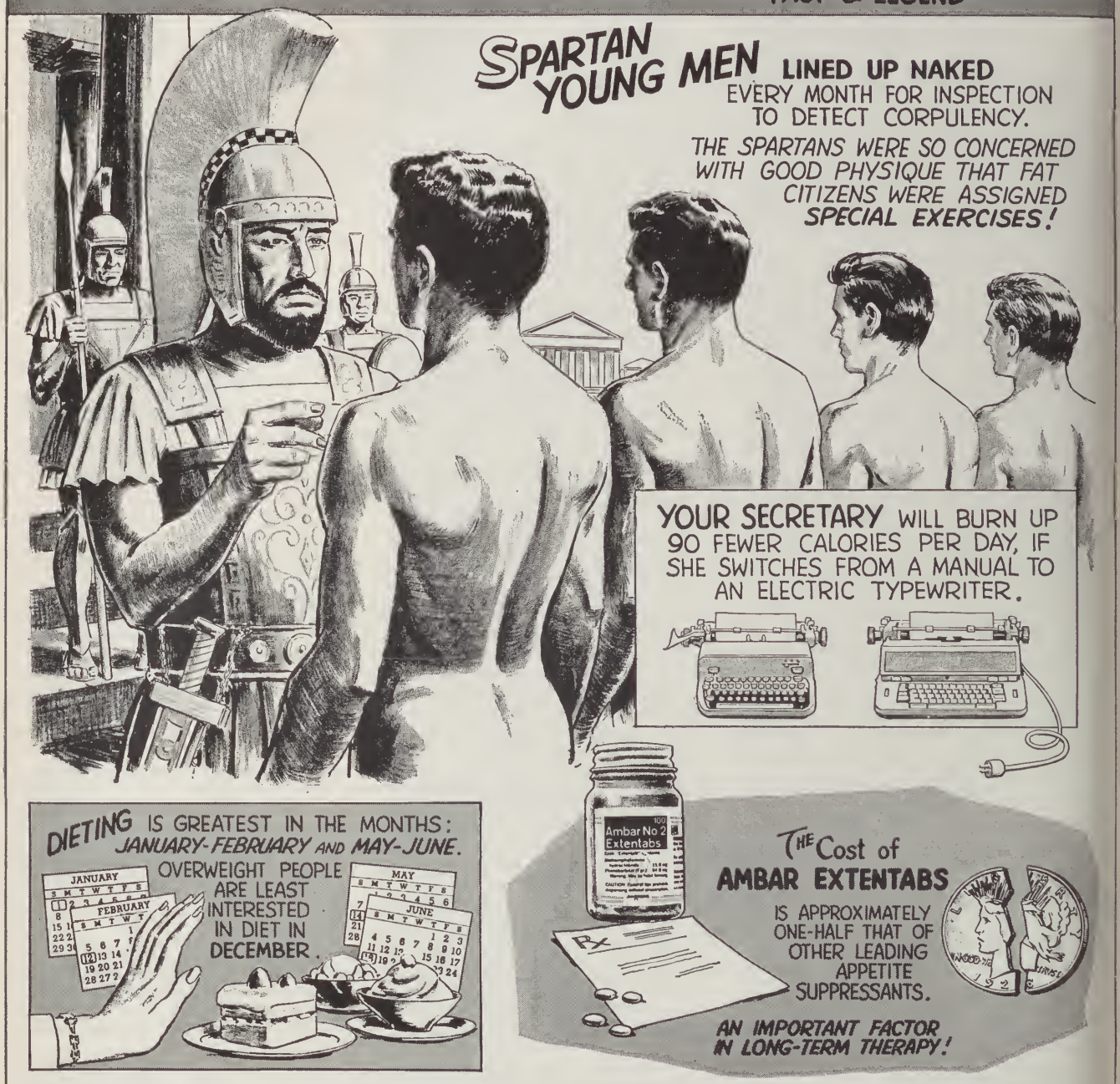
2-mg, 5-mg, 10-mg tablets *t.i.d.* or *q.i.d.*

to help relieve psychic tension
and its somatic symptoms

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBINS



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,200 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

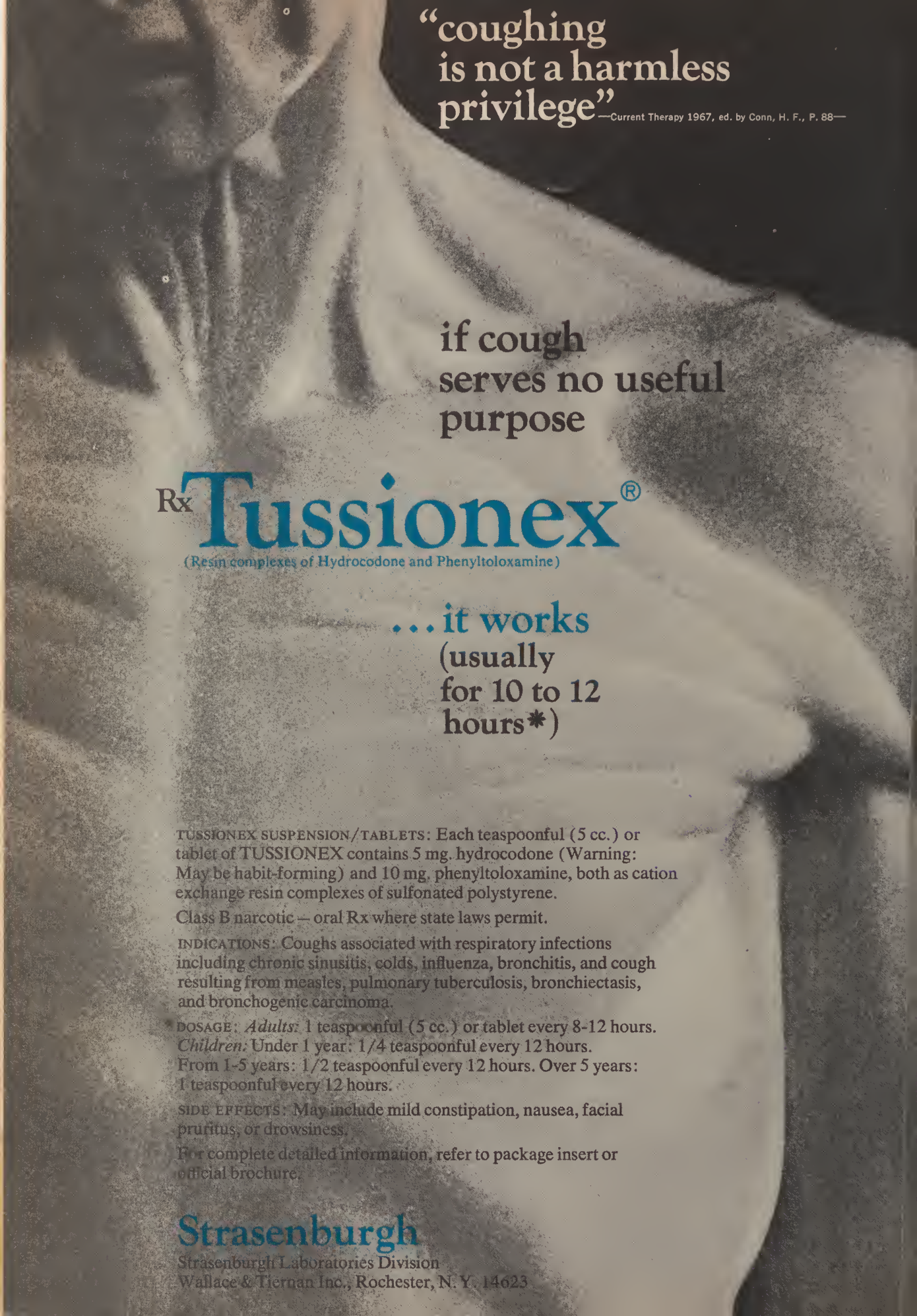
Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories

no gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID

IPC
REG. U.S. PAT. OFF.

INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

DQJ/D3H-B

HOOD CONVALESCENT HOME

"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF

CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED

National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM

Certificate Holder—Baltimore County
Fire Prevention Bureau Award

LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800

5313 EDMONDSON AVE.

DOCTORS' OFFICES

LARGE

MEDIUM

SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST. CORPORATION

11 E. Chase St.

Phone 539-8553

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected
for possible growth of principal and income.

NO SALES CHARGE

NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION

ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE
DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily
Tuesday Evenings 7 to 9

355-9300

PATAPSCO AVENUE & FOURTH STREET

Baltimore, Maryland, 21225

MEDICAL NEWS

Abraham M. Lilienfeld, MD, Chairman of the Department of Chronic Diseases at The Johns Hopkins School of Hygiene and Public Health, was recently awarded the 1968 Bronfman Prize of $5,000, an engraved scroll, and a crystal cube from the American Public Health Association for his generosity "in sharing ideas and . . . giving counsel . . . valuable assistance to students, investigators, and agencies concerned with the investigation and control of chronic diseases."

Dr. Lilienfeld was also cited as being "distinguished by a singular lack of self-interest, a great willingness to help others, and a tireless devotion to the advancement of epidemiology."

The award was instituted in 1961 as a result of a grant from the Samuel Bronfman Foundation. It is international in scope and was designed to encourage creative, pioneering work in the field of public health.

Dr. Lilienfeld's department of chronic diseases develops studies in genetics, biological aspects of chronic diseases, epidemiological, clinical, and public health aspects. The department trains graduate students in research methodology.

Other recipients of the 1968 award are **James L. Goddard,** former Commissioner of the Food and Drug Administration, and **Moises Behar,** Director of the Institute of Nutrition of Central America and Panama.

* * *

Two Maryland physicians were among the 119 radiologists who became fellows of the American College of Radiology at its annual meeting in Chicago in the latter part of February.

William S. Cole, MD, Rockville, and **Carl W. Boyer, Jr., MD,** Adelphi, received the degree of fellow for their distinguished service to their specialty. Of the 7,000 members of the college, fewer than 1,200 have been awarded the degree.

* * *

Archie B. Hooton, MD, has joined the medical staff at Taylor Manor Hospital in Ellicott City as a fulltime psychiatrist. Dr. Hooton received his MD degree from the University of Geneva, Switzerland. He has served on the staffs of St. Agnes Hospital, Spring Grove State Hospital, and Seton Institute.

* * *

During the AMA meeting in Miami last December, **Samuel Livingston, MD,** displayed his award-winning exhibit on epilepsy.

The exhibit describes the recent diagnostic and therapeutic advances which have been made in the field of epilepsy.

Dr. Livingston is Director and Physician-in-Charge of The Johns Hopkins Epilepsy Clinic.

* * *

Carolyn S. Pincock, MD, was installed as Second Vice-President of the American Medical Women's Association during the Inaugural Banquet in Boston, Massachusetts, at the Statler Hilton Hotel. Dr. Pincock was the President of Branch No. 1, Washington, D.C. for 1948-49. In June 1968, she was a Councilor at the Medical Women's International Association XI Congress in Vienna, Austria.

* * *

Michael R. Dobridge, MD, Silver Spring, has been named to the Board of the State Department of Social Services. He will complete the term of Mrs. Charles D. Harris which will terminate May 31, 1971.

* * *

Julius R. Krevans, MD, Professor of Medicine at The Johns Hopkins University School of Medicine and Physician-in-Chief at Baltimore City Hospitals, will become Dean for Academic Affairs at the school of medicine on July 1, 1969.

As a key member of the administrative staff, Dr. Krevans will assume broad responsibility for the development of educational policies, including post-doctoral education and curriculum development.

Dr. Krevans joined the Hopkins staff in 1950 as a fellow in hematology. From 1951 to 1953, he served his residency in medicine at The Johns Hopkins Hospital, and was appointed director of the hospital's blood bank and an instructor in medicine in the university in 1953. He was promoted to assistant professor in 1955, associate professor in 1960,

and professor in 1968. From 1962 to 1963, he served as assistant dean for student affairs at the school of medicine.

In 1963, he was appointed Physician-in-chief of the Baltimore City Hospitals.

Dr. Krevans was appointed a member of the Planning Council for the State of Maryland Board of Health and Mental Hygiene in 1964, and since 1965 he has been a member of the medical advisory committee to the national board of trustees of the Leukemia Society, Inc.

* * *

On Tuesday, February 18, **Fred N. Cole, Jr., MD,** addressed The Professional Forum at its monthly dinner meeting at the Baltimore Country Club.

Dr. Cole's address, *The Professional Man—A Conservative in a Liberal World,* touched upon various aspects of the Medicare and Medicaid Programs; and was followed by a round-table discussion.

Established in 1965, The Professional Forum is an interdisciplinary group drawn from all of the professions. Chairman of the committee on medicine is William E. Gilmore, MD. The program was arranged by J. E. Rytten, president.

* * *

Jacob H. Conn, MD, Assistant Professor of Psychiatry at The Johns Hopkins University School of Medicine, has received the Award for the best paper on clinical hypnosis presented in 1968. The Award and Certificate of Merit was presented for his paper on *Hypnosynthesis,* by the Society for Clinical and Experimental Hypnosis at the 20th Scientific Annual Meeting at the University of Chicago in November.

Dr. Conn is a past president of the American Board of Medical Hypnosis and of the National Society for Clinical and Experimental Hypnosis. He has been Acting Chief Medical Officer of the Supreme Bench of Baltimore, past president of the Maryland Association of Private Practicing Psychiatrists, and Consultant to the U.S. District Court, Public Health Service and the Veterans Administration.

In 1960 he was the recipient of the Award for the Best Clinical Contribution to Scientific Hypnosis. In 1961, he received the Raginsky Bronze Plaque for Leadership and Achievement as a "distinguished psychiatrist, teacher, scientist and pioneer in the field of hypnotherapy." Other awards include the Schneck Award for his "Significant Contributions to the Development of Medical Hypnosis," and the SCEH Presidential Award for his "outstanding work in the field of hypnosis over a period of 25 years."

* * *

George C. Alderman, MD, Dudley C. Babb, MD, and **Samuel M. M. Lumpkin, MD,** have announced their new office address. Their practice of otolarygology will be conducted in the Charles Fountain Professional Building, 6301 North Charles St., Baltimore.

* * *

New diplomates of the American Board of Anesthesiology include **OK Hyung Kang, MD,** Silver Spring; **Sheppard Kaplow, MD, Thomas C. McAslan, MD,** and **Eugene J. Pantuck, MD,** Baltimore; **Sandor Paskin, MD,** Rockville, and **McKim Williams, MD,** Bethesda.

* * *

Andrew J. Brennan, MD, has announced the opening of his new office at Georgetown Doctors Park, 5415 West Cedar Lane, Bethesda.

Dr. Brennan is engaged in the practice of internal medicine and allergy.

* * *

As of June 1, 1969, the new professor and chairman of the Department of Public Health Administration of The Johns Hopkins University School of Hygiene and Public Health will be **Arthur Bushel, DDS, MPH.**

Dr. Bushel will succeed **Dean John C. Hume** who will continue to hold a teaching position in the department in addition to his responsibilities as Dean.

A dentist with extensive experience in public health administration, teaching and consultative work, Dr. Bushel received his graduate degrees from Columbia University. After completing his public health training, he became Assistant Director of the New York State Department of Health's Bureau of Dentistry; Director of Dentistry for the New York City Department of Health; Special Assistant Commissioner and Director of Dentistry and Assistant Commissioner for Professional Staff Services (New York City). He has been First Deputy Commissioner since 1966, and was Acting Commissioner of Health from January to May, 1966.

* * *

A new National Cancer Institute-Veterans Administration Medical Oncology Service has been established at the Washington, D.C. Veterans Administration Hospital. The service will function both as a part of the medicine branch of the National Cancer Institute, National Institutes of Health, and the Washington, D.C. Veterans Administration Hospital Medical Services.

Oleg S. Selawry, MD, former chief of chemotherapy at St. Jude's Children's Research Hospital, Memphis, Tennessee, will head the new service.

The service will plan and conduct clinical trials with new and established anti-cancer drugs and investigate the activity of new agents. It will also evaluate the possible role of the body's defense mechanisms in influencing the survival time and response to treatment of patients with lung cancer. In addition, Dr. Selawry and his associates will join investigators from other units of the National Cancer Institute's Clinical Trials Area in a study of cell kinetics in patients with solid tumors.

A 30-bed facility at the VA Hospital will be devoted to the cancer chemotherapy studies. At the present time, the unit has two senior investigators, a junior physician and a VA staff physician, in addition to Dr. Selawry.

* * *

The Leukemia Society of America has presented new guidelines for the administration of its Patient-Aid Program.

The Leukemia Society is a national voluntary health agency with chapters in over 60 cities. It is prepared to offer leukemia patients in need of assistance four basic types of aid:

- drugs used in the care, treatment, and control of leukemia
- laboratory fees
- transfusing of blood, including processing, typing and cross-matching
- transportation

Additional information about the Leukemia Society of America Patient-Aid Program may be obtained by writing or telephoning the society's local chapter offices or the national office at 211 East 43rd St., New York, N.Y. 10017.

* * *

C. Rollins Hanlon, MD, Professor of Surgery and Chairman of the Department of Surgery at St. Louis University School of Medicine, St. Louis, Missouri, has been named Director-Elect of the American College of Surgeons.

Dr. Hanlon will assume the directorship of the college soon after the close of the 1969 Clinical Congress in October.

A graduate of Loyola College, Baltimore, Dr. Hanlon received his MD degree from The Johns Hopkins University School of Medicine in 1938. He interned in surgery at The Johns Hopkins Hospital and served as the W. S. Halsted Fellow in Surgery. He was instructor and resident in surgery and later became associate professor of surgery before assuming his present position at St. Louis University and surgeon-in-chief of the St. Louis University Hospitals.

* * *

The Johns Hopkins Medical Institutions have announced the appointment of **Torrey C. Brown, MD,** as head of the development of the Hopkins' out-of-hospital health care programs in East Baltimore.

Dr. Brown, an Assistant Professor of Medicine at the school of medicine and a physician on the hospital staff, will be an Associate Director of the Office of Health Care Programs, which was formed in December by actions of the university and hospital boards of trustees.

Initially, Dr. Brown's efforts will be in planning a comprehensive health care system for the community combining the services of local physicians, other hospitals, the City Health Department, the Model Cities Agency, and other existing agencies.

* * *

MED-CHI ANNUAL MEETING

APRIL 9, 10, 11

For information on the happenings,

see pages 25, 27 and 29.

The Preceptorship Program of the

One of the principal projects of the Maryland Academy of General Practice this past summer was the initiation of a preceptorship program. The Academy provided a stipend for the students interested in having this experience.

Although the MAGP's main medical interest lies in the area of family practice, preceptorship programs are not solely a function of the family physician. The purpose of this article is to allow both the student and the preceptor to describe this new experience and to encourage other medical groups to become involved in similar programs.

Mr. John Wilson, one of the students, is completing his medical school training at the University of Maryland. Regardless of the direction of his medical future, the time spent last summer in the preceptorship program will certainly broaden his medical horizons.

J. Patrick Jarboe, MD, from Great Mills in St. Mary's County, was one of Mr. Wilson's

What's in a

For the Physician

J. PATRICK JARBOE, MD
Great Mills, Maryland

Due to several circumstances last spring, I was given the unexpected opportunity to have a preceptee audit my practice. I found I had much ambivalence concerning this possibility. Being a solo family physician in a rural area is a lonesome business and the thought of professional companionship for a month was enticing. But would the quality of care in my practice bear scrutiny? Would some brash young man from the ivory tower make my life miserable for a month by pointing out my inadequacies or acting supercilious? (You see, I'm young enough to remember the attitudes of some of my classmates in medical school.)

However, my curiosity won out, and the month of July brought to my office and home a truly delightful young man. My three children adopted him as a member of the family. My patients accepted him as my colleague. No one objected to his presence.

For my part, I began to see my patients in a different light, as they must appear to this young man. I began to more objectively consider my therapy for their various ills. My temporary colleague and I discussed the merits of various treatment plans, and I believe we both learned as a result.

The main reason for the good outcome of this project was that the young man whom I met was a fine human being. He was intelligent, friendly, and altogether fair in his approach. I only hope he benefited from the experience as much as I did.

Maryland Academy of General Practice

four preceptors. Dr. Jarboe has a very active practice, one of the most demanding in the county. He is also very active in civic affairs and has made substantial contributions to the development of St. Mary's County.

Qualifications such as these are important in the selection of preceptors. It is precisely this experience at the interfaces of professional, social and civic responsibilities that formal medical school training is unable to provide. The opportunity for the student-doctor to see how the family physician fits into and contributes to his community is a prime objective of the academy's preceptorship program.

LEON W. BERUBE, MD, PRESIDENT
Maryland Academy of General Practice

Preceptorship?

For the Student

JOHN WILSON
Student, University of Maryland
School of Medicine

The drive down to Southern Maryland July 1 was hot, but fast. Just two hours from Baltimore, my first experience in the private practice of medicine awaited. About ten minutes after meeting my general practice preceptor, he was called next door to see a neighbor who had an acute myocardial infarction. By the time an ambulance had left for the hospital, I felt as though my adventure in medicine had begun.

My interest in general practice is long standing, and like most students who have a special field of interest, I was very anxious to find out what that specialty was like in everyday, actual practice. SAMA has had a six-week preceptorship program available for years through the Sears-Roebuck Medical Foundation. Originally I had applied for that and was accepted; however, there isn't a Sears-Roebuck medical center in the State of Maryland, and for personal reasons I wanted to stay here. Having declined the SAMA offer, I heard about the Maryland Academy of General Practice preceptorship program of similar design. The academy's program is eight-weeks long; usually four weeks with two different general practitioners selected from areas in which the student would like to live, or to which he would like to commute. Since I wanted to see what rural family practice was like, I decided to accept an assignment in Southern Maryland for a month. My second month was to be spent in Hagerstown with four different GP's, a week's time with each. Dr. James Jarboe, the preceptor with

whom I spent July, is a young man, a University of Maryland graduate, and I feel, an excellent clinician. Both he and his wife and three children made my stay in St. Mary's County very pleasant and educational. Although we all profited from the month, undoubtedly I owe the greater debt, for the amount of material I learned at this stage of my career will be invaluable, no matter what future I might have.

The everyday practice of family medicine would amaze most medical students. One of the first patients I saw was an old farmer who hadn't been to a physician for 20 years. He had severe, far advanced rheumatoid arthritis involving most of his joints, and yet, his only complaint was that he couldn't get along as well as he used to driving his tractor. In the hospital, one of the first patients was a ninety-four-year-old Negro lady who had diabetes, several paralyzed limbs, and gangrene of the toes and foot on one side. She had been scheduled for surgery several times, but cancelled because of acute bouts of pneumonia. She was finally done under local infiltration anesthesia and did well. However, she died two days later, rather suddenly. Later that night while we were in the Emergency Room, a middle-aged woman came in and handed Dr. Jarboe a placenta in a paper towel. Early the next morning before breakfast, we got a call from the hospital about one of our OB patients who was about to deliver. When we arrived there I began to scrub for the delivery. Just as the girl started to crown, Dr. Jarboe was called for a cardiac arrest on the patient he admitted the first day of July. I was left holding the baby and bag literally, but fortunately everything went according to nature. Later that morning office hours, as always, brought interesting patients. Perhaps one quarter to one third of the patients a GP sees have dermatological lesions. I saw patients with classical lesions of erythema multiforme, erythema nodosum, lichen planus, and even a case of sarcoidosis, first discovered because of cutaneous manifestations. Many cases of atopic, seborrheic, and contact dermatitis appeared daily. For the first time in my medical career, diagnosing and treating these conditions became a lot of fun. Ear, nose, and throat exams and disorders are also quite important in general practice. A large number of people come to a doctor because of ENT allergic manifestations. Problems of management of an allergic patient there can be very difficult because of financial and logistic considerations. I soon learned that management of every patient is not always one-two-three, as stated in the text books and often heard at medical centers. It is important to be able to quote the theoretically correct therapy for a certain condition, but at times deliverance or implementation of that choice is literally impossible.

I frequently saw patients with the common diseases and complaints that are prevalent in most communities in the United States: diabetes, cardiovascular disease, especially hypertension, chronic obstructive pulmonary disease, menopausal symptoms, osteoarthritis, headaches, URI's, and of course, cancer of all types. The list of conditions could go on ad infinitum because in the course of a month, one sees well over a thousand patients and just about every category of disease. Some of the patients had rarer conditions and usually classic forms of their illness. A young housewife had had mild prodromata and subsequently developed characteristic pleurodynia. A fifty-year-old man had a text book case of rheumatic heart disease with mitral stenosis. After some relatively minor stress his disease again began to decompensate and develop into pulmonary edema. This time he was convinced he should have surgical correction.

Perhaps I should mention that none of the GP's with whom I lived did any but the most minor surgery, mainly lacerations and mole removal type of procedures. However, on one occasion we were greeted with a comical situation calling for a sure knife. One of Dr. Jarboe's patients, an old friendly man with Parkinsonism, appeared on the back porch of our office building with his penis caught in his pants zipper. After working to free it for about two hours, he finally thought it time to call for help, but said he didn't know whether to see a doctor or a blacksmith. We had to do a partial circumcision in the office to relieve his embarrassment.

At the end of the month, my wife and I spent a well-deserved weekend together. Unfortunately she couldn't accompany me the entire time, but we were able to see each other about every other weekend.

Hagerstown has a population of about 40,000 with another 40 to 50,000 in surrounding com-

munities. The four general practitioners with whom I worked were in an association of sorts, which allowed each of them to have at least every other weekend off and three out of four Thursday afternoons off. All had separate offices and slightly different types of practices.

My first night's sleep in Hagerstown was interrupted at 3 AM by a hospital call for a delivery. My preceptor and I raced across town in his TR-4 with the convertible top down. By the time I got there I was wide awake and ready to catch the baby. Office hours the next day seemed long, but not as long as the next day after we again had been called the second consecutive night for a delivery which turned into a Caesarean section.

Many of the patients in Hagerstown had conditions similar to those I've already mentioned. However, a few stand out as different and unusual for many reasons. I made a house call on a middle-aged man with a familial type of progressive muscular dystrophy. The disease was present in typical form and had manifested itself in his family, in his brother and uncle, and could be traced to progenitors in Germany. In his case, as in others of a chronic and progressive nature, one looks for practical things which can help the patient withstand the emotional and physical devastation associated with their process. The value of a personal physician's concern and consolation to a patient of this sort was again reinforced in my mind.

Two of the other physicians with whom I lived were County Medical Examiners for Washington County. On one occasion we got a call from the State Police about an old man who had been found dead in bed. When we got there we could smell the decomposing body as soon as we got out of the car. He had been dead for about three days and had lain in a hot room. There must have been a hundred thousand flies in the dilapidated old room, and the smell was truly unbelievable. Later that day the odor which had permeated my clothes was still noticeable. After showering and changing clothes, I could feel clean enough to again enter the world of the living.

I'll mention a few other things which most students don't see in school, and yet will be important in private practice. Cases of chickenpox, rubella, and roseola are commonly seen, and yet I had never seen a case of rubeola, or seven-day measles until this summer when fairly characteristic disease was present in two siblings who hadn't been vaccinated.

Counseling in general, and marriage counseling in particular, becomes a difficult therapeutic challenge to the family practitioner whom I feel is in a unique position to help. Frequently, one hears the story of the young couple who "had to get married", and now he's being unfaithful and she's frigid. Another extremely common problem is the alcoholic father or mother or both who have an asthmatic child. Occasionally the undiagnosed, previously unseen, schizophrenic will walk into the office and describe delusions and hallucinations. More and more frequently these days, teen-agers are being seen in the office and emergency room because of drug or glue abuse or both.

The things I saw this summer in the individual patient were made all the more interesting because of being able to see the family interactions in relation to the disease. Anyone in any type of private practice will have to treat the family as well as the patient.

I could write much more about medical aspects of my summer preceptorship, and I could write even more about economic and practical considerations in establishing a private practice, but I'll let the reader discover those things for himself. My highest recommendations to the Maryland Academy of General Practice and its summer program.

———O———

Alcoholism – Obesity "Sans" Teeth?

Both the alcoholic and the obese patient have much in common in their behavior, *ie*, particularly the route of input. Both behaviors—eating and drinking—are not detrimental per se, but with an increase in frequency there is also a decrease and exclusion of other alternative, more adaptive behaviors. Because over-eating or over-drinking is essentially a sociological phenomenon, where some evidence would point to the dependency also being an expression of cognitive style, social therapy would seem appropriate. The alcoholic is a person within a social system who has a limited number of ways to behave within that system. By placing him in a social system such as Alcoholics Anonymous or group therapy, new behaviors or behavioral modifications may occur and thus open up new, more adaptive alternative ways of behaving within the social system. However, the social system, to be therapeutic, must also be open so that when each alcoholic patient hits a stumbling block and regresses to prior alcoholic behaviors, the therapeutic system (be it Alcoholics Anonymous, group therapy, family therapy, or even individual therapy) must be able to allow for this episode and utilize it for further work. The treatment of the alcoholic, as with the obese, is not merely a medical or a social problem but is both, and both systems should be complementary to each other rather than being competitive or mutually exclusive.

MERRILL I. BERMAN, MD
Assistant Chief, Psychiatry Service
Public Health Service Hospital
San Francisco

The similarities between polydipsia (alcoholism) and polyphagia (obesity) have been noted for some time, and these behavioral similarities were brought out during group therapy sessions with obese patients in an anti-obesity clinic.[1] Since then, further experience with alcoholic patients has brought out increasing interest in the phenomenological overlap between what are two of our greatest public health problems, the obese patient and the chronic alcoholic.

Surveying the literature, it is evident that there are multiple therapeutic regimens suggested for both with usually discouraging results and a somewhat nihilistic and often hostile approach by the medical profession, especially towards alcoholism.[2-5] However, outside of the medical arena, the major breakthroughs have been made in social innovations where "birds of a feather flock together" for mutual support and therapeutic attempts. The success of Alcoholics Anonymous far out-shadows any known medical onslaught to the problem of alcoholism, and recent organizations such as Weight-Watchers and TOPS (Take Off Pounds Sensibly) are gaining in momentum and success in the social therapy of obesity. Because both over-eating and over-drinking have the same

area of input, *ie,* the mouth, and this is our first social area of relating, it seems that the alcoholic maintains the more regressive, dependent, "toothless" position while the "carboholic" [6] has progressed slightly further, added teeth and thus, has become a somewhat different phenomenon, but with similarities that cannot be ignored.

From the medical-pathological vantage point, both obesity and alcoholism have greater morbidity and higher mortality, but from a sociological point, they are handled quite differently. Alcoholism has recently been seen as a "disease" rather than from the traditional viewpoint as criminal or immoral behavior. However, neither is properly dealt with as a disease entity, but rather may be more clearly seen and appreciated as a manifestation of a behavioral deficit.[7] By this is meant that the alcoholic, like the "carboholic" manifests a circumscribed number of behavior patterns available and uses these to the exclusion of alternatives, not because of weakness of character or immorality but because of a lack of suitable and adaptive behavior patterns. The alcoholic uses drinking behavior because he has no other methods to use in social or tense situations. The same is true of the obese patient who uses food in lieu of other social relationships to deal with loneliness, stress, frustration, or the entire gamut of emotionally charged situations. They eat or drink because they have no other behaviors available to utilize in place of these repetitious and highly cathectic, reliable behavioral forms.

At one level, the over-eater is more advanced, using teeth (aggressive behavior) while the alcoholic uses a less advanced "toothless" oral behavior, both trying to fill some emotional void or need which they cannot seem to fulfill in alternative, more adaptive, less self-destructive manners. In a study of obese patients, it was found that eating behavior occurred continuously through the day, thereby taking up a good deal of behavioral time and excluding the possibility of using or learning alternative and incompatible behaviors which could compete with eating behaviors.[8] The same thing is true of alcoholics, *ie,* the chronic alcoholic is one whose drinking behavior is so pervasive and pre-potent that it precludes other more adaptive behaviors and thereby causes much time and effort to be concentrated on imbibing rather than learning and utilizing newer and more adaptive non-alcoholic behaviors. From a behavioral point of view, it was consistently shown that group therapy and group discussions for obese patients were easily used as methods to bring together people who could talk about food, and feeding behavior, in place of actually engaging in eating. Then, through successive approximations, new and gratifying social behaviors could be elaborated upon, eliminating the need for overt eating behaviors.

It seems obvious that the support and long-term therapy of our own anti-obesity clinic milieu allowed for long-term therapy and behavioral change. The crux of the therapeutic regimen was that the patient was not treated for a month, or some other short-term program, but rather a more rational long-term group supportive gestalt was established and maintained. When the clinic or group contact ended, there was a regression to the previous level of functioning by some, *ie,* a return to the eating behavior and a return to the previous non-adaptive obesity-oriented behavior. However, such long-term, open-ended groups as Weight-Watchers and TOPS offer essentially the most rational method of dealing with this rampant sociological problem. The same can be said of Alcoholics Anonymous, a non-medical, sociological, long-term organization which offers an opportunity for learning new behaviors which compete with the previous self-destructive oral alcoholic behaviors (as is so with Synanon for drug addicts, etc.). Thus, we can move from the problem of obesity with its variety of causes and precipitating factors into the problem of its toothless cousin, alcoholism.

It seems that if we are to understand alcoholism (phenomenologically), we must move from our traditional medical-pathological viewpoint which encourages us to view the alcoholic as being one who drinks, has cirrhosis, portal hypertension, etc., into the more realistic descriptive realm of a social setting where an obese person is not one who eats "too much" but one who eats one meal a day all day long, thus excluding other possible behaviors in a social context. Also we find the alcoholics a medical, social dilemma which does not seem to have an obvious adaptive alternative. It seems that the medical-pathological gestalt has not arrived at the answer point and that a new broader viewpoint is desperately needed. Thus, one must propose a social, behavioral, phenomenological point of view to be of the utmost importance.

Thus, by implication, Alcoholics Anonymous as a sociological force provides an arena for the learning, acquisition, and reinforcement of new social behaviors.[9] In referring a patient to Alcoholics

Anonymous, there are a number of tactical problems which must be dealt with more effectively. The first is a doctor-patient relationship which allows for a referral to Alcoholics Anonymous. As most physicians know, Alcoholics Anonymous is not medically or psychiatrically oriented so that the physician is making a referral outside of the medical system. Because of this, many doctors frequently make the referral as a "last ditch" move without helping the patient to gain and maintain the motivation to seek the help available. A much more useful method would be for a physician who has an alcoholic patient population to become known to and known by the local Alcoholics Anonymous chapter. This way, the patient, who must first admit that he is indeed an alcoholic, can be contacted by an Alcoholics Anonymous representative who acts as a systems liaison between the medical system and the social Alcoholics Anonymous system.[9] After the physician has formed a satisfactory liaison with Alcoholics Anonymous, the next problem becomes more amenable to resolution. Oftentimes, alcoholics will insist that they have been through the Alcoholics Anonymous route and it doesn't work. While there may be some negative transference or some reality factors operating, this is usually best dealt with as a resistance to therapy. The patient may also be hearing the physician rejecting him (a frequent occurrence with alcoholics) and it is important that it be made clear that Alcoholics Anonymous is an adjunctive service to the doctor-patient relationship. Operating in this paradigm is the often encountered, regressive desire or fantasy that the doctor-patient one-to-one relationship will magically resolve the patient's inner turmoil and satisfy his basic oral dependency needs. Through Alcoholics Anonymous or other goal-oriented group programs, this magical quest may be dealt with through the acquisition of new social group behaviors.

At this point, it may be of great interest to introduce some experimental work which substantiates the group therapy approach to alcoholism. Witkin, et al,[10, 11] have shown that each person has a certain cognitive style with some people being very dependent on external cues to moderate their own behavior with very little internal motivational dependence. At the other end of the continuum, are those who operate according to almost exclusively internal cues, tending to negate or deny obvious external cues. In general, the alcoholic, both male and female, has been shown to be more dependent on external feed-back.[10, 11] People whose cognitive style is so externally dependent tend to be seen as passive, dependent, have low self-esteem, etc. While the work on cognitive style does not tell why people will sometimes become alcoholic or sometimes obese or schizophrenic, it does suggest that our therapeutic goals could make better use of the cognitive style in influencing our method of offering new data or alternative behaviors to a wide spectrum of patients. Boiled down, this means that modeling or behaving in front of the patient allows them to mimic or "incorporate" these newer forms of behavior, which is so obvious in the mimicking behavior of children and one of the characteristics of our species.[12] This modeling of behavior also occurs in one-to-one insight-directed therapy, but as one knows, many alcoholics as well as schizophrenics or patients have a great abundance of insight, but no way to put it into overt behavior.

The Alcoholics Anonymous sessions as well as group therapy programs offers this in an acceptable form. One should also keep in mind that the alcoholic behavior is pre-potent, that is, well practiced and readily available. Thus, in a tense situation, the patient can always regress, use a prior behavioral pattern, *eg,* drinking, so that any program aimed at therapy and rehabilitation must take into account the tendency for relapses which are then used in the the therapeutic regimen rather than being the criterion for exclusion from the program. It is almost as if the alcoholic lacks the teeth to cling to the nipple of therapy and we must respond at this dependent level.

REFERENCES

1. Berman, M. I. & Anderson, I. R., Comparisons of Weight Losses with Three Reducing Regimens—Diet Therapy, Phenmetrazine, and an Amphetamine Combination., *J. American Geriatrics Society,* 14: 623 1966.
2. Falconer, H. S. & Greenwood, J. H.: Alcoholism, A Way of Life, *The New Physician,* May 1962.
3. Alcoholism Challenges the M.D., *Medical World News,* Sept. 16, 1966.
4. McCormick, E. W.: Punitive Approach to Alcoholism, *Geriatrics,* June 1966.
5. Van Fleet, Charles: Help for the Hospitalized Alcoholic, *J. of Rehabilitation,* March, April 1967, Vol. 33, No. 2.
6. "The Carboholic", *J. of Obesity,* Vol. 1, No. 1, 1965.
7. Berman, M. I. and Anderson, I. R.: Obesity: A Manifestation of a Behavioral Deficit, *Clin. Med.,* 73:59, 1966.
8. Berman, M. I. & Anderson, I. R.: Eating Patterns in Obesity, *Md. State Medical J.,* April 1966.
9. Some Questions We Asked Alcoholics Anonymous, Resident Physician, March 1968.
10. Witkin, H. A., Karp, S. A., and Goodenough, D. R.: Dependence in Alcoholics, *Quart. J. of Study on Alcoholism,* 20:493, Sept. 1959.
11. Karp, S. A., Poster, D. C. and Goodman, A.: Differentiation in Alcoholic Women, *J. of Personality,* 31:386, Sept. 1963.
12. Morris, Desmond: The Naked Ape, McGraw-Hill Book Co., N. Y. 1967.

Alcoholism is not common in certain people who have a high alcoholic intake. Some eminent specialists stand in opposition to the disease concept of alcoholism. It is not true of other diseases that they can be overcome completely by negative conditioning.

There is no satisfactory or generally accepted definition of alcoholism. Diagnostic and conclusive laboratory, physical, or other signs are lacking. The reasons are not clear why various individuals and groups strive to establish it as a disease. However, such proponents have been known to apply themselves with more zeal than cogency in support of the contention that alcoholism is a disease.

Alcoholism Is NOT a Disease

ERNST SCHMIDHOFER
Director, Professional Education & Training
Professional Education & Training
Clifton T. Perkins State Hospital
Instructor, Department of Psychiatry and the Behavioral Sciences
The Johns Hopkins University School of Medicine

The U.S. Court of Appeals in Richmond, Virginia has said that alcoholism is "now universally accepted medically as a disease."[1] In this paper I should like to offer a dissenting opinion.

From the etymological standpoint alcoholism is a disease. But only because the prefix "dis" means bad and the suffix "ease" means comfort. There seems to be little real justification for calling it a disease although, not uncommonly, there are heavy overtones which imply much more than that.

It is difficult to ascertain whether alcohol causes the disease, or whether it is part of the disease, or both. In any event, it has been pointed out by sociologists that the Italians and the Jews have a high alcoholic intake but a low alcoholic incidence. If alcohol produces a disease or if it is part of a disease, why isn't it present much more often in those two groups? The exposure in them is high, but the frequency is low.

What is the cause of this "disease"? How does it originate? When does it become a disease? If we don't know what causes it or how it originates or when it becomes a disease, how can we call it a disease?

According to McCarthy,[2] the definition of alcoholism in terms of a disease is not recent. He credits the Scottish physician, Dr. Thomas Trotter, with having said in 1804: "In medical language, I consider drunkenness, strictly speaking, a disease; produced by a remote cause, giving birth to actions and movements in a living body, that disorders the functions of health. . . . It is to be remembered that a bodily infirmity is not the only thing to be corrected. The habit of drunkenness is a disease of the mind."

There appears to be a serious weakness inherent in his statement of position. Reference is made to the terminal phrase "disease of the mind." Is it

tenable to attribute the fictitious construct "mind" with the property "disease"? By standard definition, the latter term should be reserved for that which is organic or structural and has substance.

Furthermore, even though Trotter made his pronouncement in 1804 doesn't mean necessarily that it was correct then or now. Surely we would all agree that long before Trotter many things were said by Hippocrates that weren't true then or now either.

McCarthy then cites from the writings of another physician.[3] He excerpts from a monograph on alcoholism which was written in 1854: "And the complex nature of the disease, varying both in cause and effect with every form of constitution and habit, renders it extremely improbable that any such specific will ever be discovered."

The author's reference to the word "specific" is a preventative of further indulgence. Evidently Dr. Day felt sufficiently secure, scientifically, to say it was "extremely improbable" that a specific form of treatment would ever come into being. In terms of degrees of probability, I would venture to say this prediction makes it extremely unlikely that alcoholism is a disease.

Dr. Ruth Fox, research director for the National Council on Alcoholism, has expressed disagreement with the notion that alcoholics are neurotic and rejects the notion that there is a pre-alcoholic personality type. This point is introduced because some people consider alcoholism to be a disease since they view it as a neurosis. In the first place, this notion is not shared by some of our most eminent specialists in the field. Secondly, even if alcoholism were a neurosis, this would not make it a disease because a neurosis is more properly considered to be a disorder.

The distinction is not always made between disease and disorder. Nevertheless, a disease shows itself to be organic in nature, demonstrates abnormality of structure, and evidences anatomic change. On the other hand, a disorder shows itself to be functional in nature, demonstrates abnormality of performance, and evidences physiologic change.

Psychiatric formulations have, at times, been resorted to in an attempt to interpret alcoholism as a disease. According to Isbell,[4] these cannot be proved in the strictly scientific sense. He feels that the best formulation at the present time for the phenomenon of craving is a psychiatric one. It would appear such an interpretation by a scientist of Dr. Isbell's stature, lessens the logicalness of the argument that alcoholism is a disease. It seems that things psychiatric are much more likely to be functional than organic. Surely a craving is better classified relatively as a disorder rather than as a disease.

Upon listening to and reading about alcoholism as it is presented by the champions of the notion that alcoholism is a disease, it is easy to conclude there is supposed to be some sort of defect or shortcoming which separates the alcoholic from all others. But as Isbell points out, after a few days or a week of abstinence the alcoholic is physiologically indistinguishable from his fellows unless he has incurred one of the structural derangements which may be associated with alcoholism.[4]

Diagnostic and Statistical Manual

The American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders [5] lists alcoholism under the section on personality disorders and speaks of it as being a disorder without producing clearly defined tangible structural change. Certainly this does not lend strong support to the disease concept, at least from the standpoint of the definitions which have been submitted in this paper.

The president of the International Center for Psychodietetics in Rome, Italy[6] indicates it is lamentable to hear time and again the statement made that alcoholics need help because they are "sick" or "diseased" or "ill." He says, "we have no right to state than an 'alcoholic' is diseased in the same sense as the person suffering from pneumonia or rheumatic fever."

Another distinguished scholar, Esser,[7] feels that the disease concept of alcoholism "must not be extended to all forms of excessive drinking." He declares also that there are those excessive drinkers who imbibe for as long as 30 years without developing loss of control.

Whereas it has been argued that heavy drinkers develop cirrhosis and fatty degeneration of the liver, not every scientist of renown would agree with this. Among those who demur is Dr. E. Jacobsen, a Danish expert.[8]

Dr. Jacobsen does not believe there is a shred of truth in the notion that alcohol poisons the liver. Furthermore, he feels that abstinence, which is so commonly prescribed in liver disorders, does not particularly help restitution of a liver which is already diseased.

Dr. Morris Chafetz, psychiatrist and director

of the Alcoholic Clinic of the Massachusetts General Hospital, who is also special consultant for the National Institute of Mental Health, points out that alcoholism should not be considered a disease. He views it rather as a symptom "of a wide variety of underlying emotional, physiological, and social problems." Furthermore, it is his opinion that "most professionals in the field prefer the view that alcoholism is a symptom analogous to headache or fever." [9]

The human body may be conveniently classified into the following systems: (1) skeletal (2) muscular (3) vascular (4) neural (5) special senses (6) respiratory (7) digestive (8) endocrine (9) reproductive (10) urinary (11) skin.

Of all the diseases known to afflict those 11 body systems, I do not think of a single one which can be overcome completely by negative conditioning, as by means of injecting apomorphine. But alcoholism can. Again, this does not seem to speak for it as being a disease.

O'Halloren states he has given the aversion treatment over 75,000 times in treating a series of 10,000 alcoholics. He reports the following results: "Physicians utilizing this program of management for their alcoholic patients may expect total sobriety ranging from one year to life in more than 60% of those treated." [11]

This investigator indicates he compiled his statistics accurately and carefully over a period of 21 years. Considering the fact that he uses the aversion treatment, the remarkably high incidence which he reports with the use of that method is impressive. It is impressive not only in terms of the good results obtained, but also because the effectiveness of that technic makes it appear unlikely that alcoholism is a disease.

Coming back to all the diseases that are known to afflict the 11 body systems, which ones or which one of them will respond to conditional reflex therapy to the degree that the physician utilizing such a program can expect complete recovery ranging from one year to life in more than 60% of 10,000 of such cases which he treats?

It has been noted that the decision of an alcoholic to stop drinking is often prompted by threats of one sort or another. It may be loss of a job. It may be dissolution of the family. There may be factors which threaten his security. His physical health may become impaired severely. He may lose the respect of his associates.

Many alcoholics will agree to treatment only after the spouse files suit for divorce, or when the employer makes it clear that continued employment depends upon elimination of the drinking problem.

Of all the diseases which are known to afflict the 11 body systems, which ones or which one can be held under control, and like alcoholism, be kept from coming into existence through making any of the decisions or any of the resolutions mentioned in the paragraphs above?

There are ethical, as well as technical reasons, for arguing against the notion that alcoholism is a disease. For one thing, to consider it as a disease tends to foster dependency needlessly, even in those who are tempted to resist this state. For another, this consideration turns the focus of attention away from the cause and, therefore, will almost certainly delay the time that will be required to discover or develop a cure which is suitable and satisfactory.

In her customary scintillating style, the illustrious writer Schmideberg, equates some of the promises of psychiatry with hopes and disillusionment. She points out that the journalese term "sick" was coined in order to evoke sympathy for delinquents. The chief drawback to this is it "glosses over the fundamental issue as to what is wrong with the offender."[12] Almost certainly this very same factor is operative with reference to using the "sick" approach to alcoholics.

Perhaps one of the most unsatisfactory aspects of the concept that alcoholism is a disease is there is no satisfactory or generally accepted definition for the condition of alcoholism. Surely this does not contribute heavily to the justification for considering it to be a disease.

There seems to be general agreement that a disease is characterized in part by gross and/or microscopic pathologic changes. It is an affliction which is organic rather than functional. If alcoholism is a disease, where is the pathology? If alcoholism is a disease, what is the pathology?

It appears the sponsors of the concept that alcoholism is a disease have little more to show than physiological changes such as vasodilation, and a biochemical one resulting from an increase in the blood-alcohol level. These alterations can make alcoholism eligible for consideration as a disorder, but hardly as a disease.

No Pathognomonic Lab Findings

Of all the laboratory studies extant, I do not think of one that has been established to make the determination that alcoholism is a disease. Nor

do I know of any other means whereby this can be done.

Other demonstrable diseases have identifying physical signs and characteristics or other criteria for validating them as being organic maladies, either ante mortem or post-mortem. Is this true for alcoholism? Not insofar as I am aware.

Alcoholism will make a person dizzy and dystaxic. But so will self-induced whirling. Does this make self-induced whirling a disease? If not, why not? The answer to these questions and related ones should make possible a clear and easy and clean-cut distinction between alcoholism as a disease entity, and other disorders which it may resemble. Yet, these answers do not seem to be forthcoming from anyone anywhere.

It does seem strange that of all the people in the world who pronounce alcoholism to be a disease, no one has brought forth facts which confirm this as a verity.

It has been said that a "dry" drunk consists of experiencing the same symptoms as having drunk heavily without actually having imbibed any liquor. What other disease can be reactivated in terms of simulation, in the absence of the item or elements which caused it?

One of the reasons for so much vigor behind the disease concept of alcoholism may be the fear that if this appelative foothold is lost, the alcoholic will be dealt with harshly, rather than treated comfortingly. But surely a shift to the non-disease concept will not induce a gentle therapist to become harsh, any more than adherence to the disease notion will induce a harsh therapist to become gentle.

From the standpoint of probability, efforts to justify alcoholism in terms of a disease, in the absence of good and valid criteria, speak strongly against the likelihood that such indeed is the case.

Because the alcoholic is sick does not prove he has a disease. Motion sickness or drinking too much salt water or eating too many doughnuts can make us sick, too. But that doesn't mean we have a disease.

Many less articulate alcoholics intensely resent the hue and cry that is put up by some of their more vocal brethren. It would appear that some of the latter exploit the disease concept of alcoholism not so much from the standpoint of getting sympathy as they do for making a bid for attention. There is evidence that some do this to provide themselves with an acceptable social excuse for their own ineptness or inadequacy. These traits are then ascribed to all alcoholics, including those who neither want them nor have them.

To speak of alcoholism as being a disease, or to say "unquestionably the alcoholic is a sick man", betokens certain precious values. If a man is sick, then he is deserving of pity. He is also eligible for varying quantities of sympathy. Furthermore, there may be coming to him gratuities and financial support from various sources and organizations.

For him to be sick creates a good image in the eyes of the public, and someone is likely to lend him a helping hand. Legislation may be enacted and research monies may be granted for the construction of hospitals and sanitaria dedicated to his care and protection.

Another view of alcoholism shows it to be not so much a disease as a problem. One could even say it is no more a disease than are other episodic disorders such as, check forging, kleptomania, pyromania, and tantrum throwing.

On occasion, alcoholism is spoken of as though it were an addiction. And there appears to be some evidence that it is an addiction. However, this does not give much strength to the disease concept. Any number of the following might also come under the category of addiction. I include now cigarette smoking, competing, complaining, overworking, speeding, succeeding, swindling, taking sedatives, using laxatives, viewing the television, and vying with slot machines. But are these diseases?

Daytop Drug Addiction Concept

The acronym "Daytop" stands for drug addiction treatment of probationists.[13] This group consists of self-reforming drug addicts. They contend that drug addicts do not suffer from any exotic form of disease.

The group numbers more than 100 members ranging in age from 18 to 45. These men and women see drug addiction as an outstanding example of one consequence which can result from attempts to dodge life's basic commitments.

The people at camp Daytop consider themselves as having been more skillful dodgers than most and to have succeeded more dramatically. They feel they have not assumed their rightful amount of individual responsibility.

Finally, the authorities who closely supervise Daytop are not highly enthusiastic in response to widely-voiced exhortations for cures with some

miracle drug. Their unresponsiveness to such excited overtures stems from the fact that, like their charges, they do not consider drug addiction to be a disease.

Some psychoanalysts claim there is a bond of union between alcoholism and certain other conditions. But rarely does anyone speak of those states as being diseases. They include: ceaseless talkers, excessive coffee drinkers, those who must continually dominate every situation, those who go on dress-buying sprees, some leaders of some clubs, over-eaters, poker players, race-track addicts, and some reformers of some societies.

It has been said that alcoholism is a disease because it is stereotyped, repetitive, maladaptive, determined, and poor in self-prediction. But such characteristics apply also to a number of diverse conditions such as, bed wetting, belching, cigarette smoking, cursing, dreaming, fighting, gum chewing, hair twisting, horn honking, indebtedness, insomnia, littering, philandering, prostituting, sleep walking, spitting, throat clearing, and thumb sucking.

Would it be proper to call alcoholism a problem rather than a disease? The answer may be posited in the affirmative because it is a problem from the standpoints of definition, diagnosis, epidemiology, etiology, family, management, recovery, society, and treatment.

Those who might find unsatisfactory the word "problem" would perhaps prefer to substitute affliction, condition, disorder, malady or state. I would guess the dissentients are among those who press hardest for having alcoholism thought of as a disease. Such a stand might be taken because of the comprehensive appreciation these people have for the semantic overtones generated in differing directions by such opposite words as "problem" and "disease."

It is acknowledged one cannot say precisely what alcoholism is in the framework of our present discussion. But this doesn't mean one shouldn't argue against what it isn't. Failure to do so would contribute to calling off a search for the actual cause. In this sense disagreement is expressed with the argument that one should not disparage a set of procedures if he cannot offer a substitute plan. Perhaps it is better to do nothing than do something wrong. *Primum non nocere.*

At the present time, the claimant majority is holding sway. But there seems to be a growing reticent minority which reasons that alcoholism can be explained much more accurately in terms of learning, overlearning, relearning, and unlearning.

It has been pointed out earlier that alcoholism may lead to disease, in the view of some people. It has also been pointed out that this does not prove alcoholism itself is a disease. Perhaps the indication is timely for a brief tautology on why alcoholism should not be classified as a disease.

When children engage in drinking contests, they may suffer from water intoxication and even death. Because they drink too much water, does this mean hyperhydration is a disease?

Overeating may lead to diabetes, heart trouble, obesity, and vascular hypertension. Because omniphages eat too much food, does this mean they must have a disease?

Consuming alcohol to excess leads to a state of insobriety. Devouring food to excess leads to a state of satiety.

Each of those two states is a condition which is temporary for a particular instance. Each is done repetitively. Each can be indicative of varying kinds of problems. Each is deleterious in the long run. Each is engaged in by all manner of men and women. Each can be started most any time. Each can be terminated most any time. And each can be tolerated up to a point. From these standpoints it does not seem reasonable that alcoholism should be classified as a disease and overeating as a habit.

One might feel that chemistry determinations of the blood could be helpful. But are they? I am not aware of any such studies, nor of any others whereby it is possible to establish as a fact that alcoholism is a disease.

(1) Blood chemistry findings do not distinguish between a teetotaler and an alcoholic who has not been drinking for quite some time. (2) The finding of alcohol in the blood enables the investigator to say the subject had been drinking recently. But he cannot say whether or not the person is a "non-alcoholic" imbiber of intoxicants or an "alcoholic" in the present sense of the word. (3) The absence of alcohol in the blood does not prove that the man is not a chronic alcoholic. He may have been abstinent for a sufficient length of time before the blood was drawn and examined.

Once again we are confronted by the issue which keeps recurring throughout this paper. What are the criteria being used by those who aver that alcoholism is a disease?

Just how does one go about establishing that alcoholism is a disease? Animal inoculation? Biopsy? Bone marrow aspiration? Cerebrospinal

fluid? Frozen sections? Gross findings? Microscopic investigation? Physical examination? Sputum determinations? Tissue cultures? Urine? X-ray studies? Just which criteria are pathognomonic and obtained from just which tests?

Just what manner of disease is it that allows for the offending agent to be reintroduced in the same quantity which originally incapacitated the individual (from an alcoholic debauch) but some years later no longer does so (after he has become a confirmed heavy drinker)?

Perhaps there are immune bodies which can account for this. One might say the alcoholic developed an immunity against a recurrence of the disease. However, as I understand it, alcohol is not known to be antigenic. To my knowledge, no one has ever demonstrated any immune body against the offending agent in an alcoholic.

Just what other disease blights such a relatively small minority when the active ingredient is consumed by an ever-increasing majority?

It would seem to be expecting much of the diagnostic and intellectual sensibilities of seasoned scientists to ask them to conclude that alcoholism is a disease which, out of 20 persons, affects one individual who drinks a certain amount of liquor, but which malady is not reproduced in the 19 others who drink an equivalent amount of the disease-producing potion.

Is there any other disease which can be turned on and off, and which is under an equivalent amount of voluntary control?

From the standpoint of turning it on and turning it off, alcoholism is no more a disease than is nailbiting. In matter of fact, the latter at least has gross evidences of structural change, both manifest and unfailing.

In successful instances, alcoholism can be and is handled satisfactorily without professional help of any kind whatsoever. Furthermore, what other disease can be held at bay so absolutely and so positively by simply climbing on the water wagon?

At this point, it would seem safe to say that alcoholism may be considered more appropriately as a condition whose primary state is not a disease and which does not begin as a disease but may lead, in time, to disease processes in the heart, the kidneys, the liver, and elsewhere.

These criteria do not lead inevitably or incontrovertibly to the conclusion that the primary state of alcoholism is a disease, or that it began as a disease. For instance, a person can go skiing (the primary state) and end up with a leg fracture. Does this mean that skiing is a disease or that it began as a disease? A person can go horseback riding and end up with a ruptured spleen. Does this mean that horseback riding is a disease or that it began as a disease? A person can go swimming and end up drowning. Does this mean that swimming is a disease or that it began as a disease?

Such considerations would perhaps allow more properly for the interpretation that alcoholism is a condition and not a disease. This is perhaps a more accurate portrayal and worthy of unimpassioned consideration partly because "condition" suggests something which is temporary and subject to control. Additionally, it indicates generally a more favorable outlook than is true for "disease."

There seems to be little difficulty in considering cancer, diabetes, heart trouble, pneumonitis, tuberculosis, and typhoid fever as being bona fide diseases. Why is there difficulty in trying to establish alcoholism as a disease? Why is there discussion about it? Why is there argument regarding it? Why are there diverging comments written about it?

Not Looking In The Right Places

Perhaps it will prove to be true that the "disease" alcoholism is not so much descriptive of an organic change, as it is representative of a chimeric idea.

And it may come to pass that up to now the search for its existence has been unrewarding because we have not been looking for it in the right places. The suggestion is that this "disease" is present not as an entity in the bodies of those who are alcoholic, but rather, as a concept in the brains of those who have labeled them so.

REFERENCES

1. *AMA News,* Feb. 7, 1966.
2. McCarthy, R. G., *The Annals of the American Academy of Political and Social Science.* 315:16, 1958.
3. Day, A., *Methomania.* James Campbell, Boston, 1867.
4. Isbell, H., *NIMH Addiction Research Center PHS Hospital.* Lexington, Ky., Feb. 1962.
5. *Diagnostic and Statistical Manual: Mental Disorders.* APA Ment. Hosp. Service, 1952.
6. Lolli, G., *Quarterly Journal of Studies on Alcohol.* 24:312-332, 1963.
7. Esser, P. H., *Quarterly Journal of Studies on Alcohol.* 24: 109-121, 1963.
8. Jacobsen, E., *Science News Letter.* Feb. 16, 1952.
9. Chafetz, M., *Medical Tribune,* May 18, 1964.
10. O'Halloren, P., *Alcoholism: Diagnosis and Treatment.* 1956.
11. Schmideberg, M., *Northwestern University Law Review.* Vol. 57, 1962.
12. Marlin, K., *The Dis-Coverer.* 3: 2, 1966.

your medical faculty at work

by John Sargeant
Executive Secretary

The Council at its January 16, 1969, meeting took the following actions:

1. Adopted the minutes of previous meetings, as well as Executive Committee sessions.
2. Waived 1969 dues for a physician who is ill, at the request of the component society involved and in accordance with Article III, Section 7, of the Faculty Bylaws.
3. Ratified various physicians' defense cases.
4. Heard of a settlement of a case wherein the judge had directed a verdict in favor of the physician.
5. Adopted the proposed 1969 budget.
6. Authorized submission of names to the Blue Shield Board for (1) nomination for election to the Board and (2) appointment to the Medical Relations Committee and Reference and Appeals Committee. These were:

Blue Shield Board of Trustees: (three-year term)

Terms expiring of:

William Carl Ebeling, MD, Baltimore	Internal Medicine
Gerald A. Galvin, MD, Baltimore	Gynecologist
Arthur T. Keefe, Jr., MD, Chestertown	General Surgeon

(All recommended for reappointment)

Others presently serving on the Board:

J. Sheldon Eastland, MD, President, Baltimore	Internal Medicine
Charles F. O'Donnell, MD, Vice-President, Towson	General Practice
Edgar T. Campbell, MD, Hagerstown	Radiologist
George D. Edwards, MD, Towson	Ophthalmologist
Claude D. Hill, MD, Baltimore	Obstetrician
William G. Speed, III, MD, Baltimore	Internal Medicine

Medical Relations Committee: (one-year term)

Consists of Board of Trustees, plus 3 additional physicians who are, at the present time:

John S. Haines, MD, Baltimore	Urologist

Recommendation that he be replaced by:

Thurston Ray Adams, MD, Baltimore	General Surgeon
W. Bradley King, MD, Baltimore	Pathology
Paul A. Mullan, MD, Baltimore	Pediatrician

(Both recommended for reappointment)

Reference and Appeals Committee: (one-year term)

W. Bowdoin Davis, MD, Baltimore	Plastic Surgery
Albert H. Dudley, MD, Baltimore	Obstetrics/Gynecology
J. T. H. Johnson, III, MD, Baltimore	Orthopedics
Nicholas Mallis, MD, Baltimore	Urology

(Continued next page)

W. Kenneth Mansfield, MD, Baltimore	Obstetrics/Gynecology
B. Martin Middleton, MD, Baltimore	Surgeon
Granville H. Richards, Jr., MD, Cecil County	General Practice
Henry H. Startzman, Jr., MD, Baltimore	Radiology
Wilfred H. Townshend, MD, Baltimore	Internal Medicine
(All recommended for reappointment)	
A. Talbot Brice, MD, Frederick County	General Practice
Recommendation that he be replaced by:	
Leon W. Berube, MD, St. Mary's County	General Practice
Harold C. Dix, MD, Baltimore	Ophthalmology
Recommendation that he be replaced by:	
Gregory John Sophocleus, MD, Towson	Ophthalmology
William B. Holden, MD, Baltimore	Psychiatry
Recommendation that he be replaced by:	
Jacob C. Handelsman, MD, Baltimore	General Surgeon
Harry M. Robinson, Jr., MD, Baltimore	Dermatology
Recommendation that he be replaced by:	
John F. Strahan, MD, Baltimore	Dermatology

7. Authorized submission of names of nominees for possible election to the Blue Cross Board of Trustees as follows:

Terms expiring of:	
B. Martin Middleton, MD, Baltimore	General Surgeon
J. Arthur Weinberg, MD, Baltimore	General Surgeon
(Both recommended for reappointment)	
Others serving on Board (physicians only):	
J. Tyler Baker, MD, Easton	Obstetrician
William D. Lynn, MD, Baltimore	General Surgeon
Richard A. Young, MD, Hagerstown	Pediatrician

8. Heard a progress report regarding the proposed Multiphasic Screening Project and adopted the following motion:

   "The Council approves of Multiphasic Screening as outlined and directs its Ad Hoc Committee to proceed with its investigations, keeping this Council fully informed of its findings and recommendations."

9. Voted that the Subcommittee on Chronic Diseases be requested to prepare a report for Council outlining the care of hospitalized Tbc patients in Maryland which would include the economic, ancillary, consultant, familial factors involved in the care rendered to such patients and make a thorough investigation as to the type and quality of care being rendered to those same patients in tuberculosis hospitals in Maryland.

   At the end of the Council meeting, the Council reconsidered this motion and adopted one that would permit the President to name an ad hoc committee to conduct this investigation, rather than referring it to the Subcommittee on Chronic Diseases.

10. Deferred endorsement of a State Health Department proposed Glaucoma Screening Project and requested a definitive answer from the Maryland Ophthalmological Society in this connection. It also authorized the Executive Committee to endorse such a project, if it deemed this advisable, after receipt of this definitive answer from the ophthalmological group. It is to be understood, however, that such endorsement would cover only the research aspects of the proposal; and not that section devoted to the establishment of mass screening projects of this nature throughout the State through the State Health Department.

11. Approved a recommendation of the Medical Economics Committee that it endorse a proposed rate increase of 19.4% in the professional liability rates offered Faculty members through the St. Paul Professional Liability program; and an increase of 25% in the basic limit rates. This will still leave the Faculty's program under national rates by 34%.

12. Heard information with respect to amounts paid to hospital educational funds by Blue Shield; and elected to ask for clarification of certain purposes for which these funds were being used by hospitals.

13. Heard a report on the 1969 General Assembly and bills affecting the medical profession.

14. Voted to table the following two motions of the Committee on Emotional Health:

    (a) All General Hospitals in Maryland should be notified again of the endorsement of the Faculty policy adopted in 1965, and offers its support for any effort on their part to develop psychiatric inpatient beds.

    1965 policy was:

    The Medical and Chirurgical Faculty of Maryland heartily supports the inclusion of psychiatric services, both inpatient and outpatient, in all general hospitals in the State of Maryland.

    (b) The Council submit a resolution to the Governor and General Assembly endorsing the request of the Department of Mental Hygiene for this item (a budgetary request of $400,000) to be included in the State Budget for the purpose of establishing a Drug Abuse Center.
    The Faculty's House of Delegates endorsed the concept of such a center at its Annual Meeting, 1968.

15. Acknowledged with thanks the receipt of $500 to be placed in the Laughlin Award Fund. The gift was made by Henry P. Laughlin, MD.

16. Adopted a recommendation of the Pharmacy Liaison Subcommittee and the Mediation Committee as follows:

    The Medical and Chirurgical Faculty of the State of Maryland opposes direct telephone lines between a physician and a pharmacist.

The Maryland Pharmaceutical Association and the C & P Telephone Company will be notified of this action.

17. Adopted the following in connection with Maryland's Medicaid program:

    The Executive Committee is authorized to appoint such Faculty members or employees as it feels necessary to properly represent the Faculty in any investigations regarding or involving physicians in the State's Medicaid program.

After adoption of this motion, the following was approved:

    If a satisfactory agreement can be reached by the Faculty and the State, that the Blue Shield Board be asked to administer the program, after it has reviewed it and is satisfied that such a program can be adequately administered.

The Council then suggested the following guidelines be used in any investigations as approved in the first motion adopted on this subject:

1. The basis for payment be the Physician's Usual, Customary, and Reasonable fee for all inpatient and outpatient services rendered Medicaid recipients by private physicians.

(Continued next page)

2. Any inpatient or outpatient care rendered Medicaid recipients by house staff, teaching staff, full or part-time salaried physicians, Fellows or any other term used for those physicians who are paid salaries, per diems, etc., by hospitals, foundations, or any other term, *where an employee relationship exists,* shall not be considered as physician's services for purposes of payment, but shall be included in hospital costs as calculated in the average per diem hospital cost of each hospital or institution.

3. Any outpatient services provided recipients at hospital OPD under Medicaid shall be billed by the hospital rendering service and paid by Blue Shield on the basis of Usual, Customary, and Reasonable fee, for the area involved. However, such payment shall then be deducted from fees paid that institution by Blue Cross or that group paying for the Medicaid patient's care so as to avoid duplication of payment and discourage overutilization by the recipients who sometimes tend to wish excess care or tend to "doctor shop" or both. Where such professional services are rendered by this mechanism, an adequate summary shall be kept so that statistical data can be provided for comparison as to the cost of care rendered in this setting as compared to a private physician's office setting.

4. That any premium per recipient be computed as closely as is humanly possible to permit payment to physicians of their Usual, Customary, and Reasonable fee and shall be based on a per month, per recipient, basis.

5. It is to be understood that, should best estimates fall short of actual costs for fiscal 1970, the physicians of Maryland will underwrite the program by accepting a reduction of their Usual, Customary, and Reasonable fee to a percentage that will allow the program to function within the funds received through the rate charged.

6. It is also understood that this is for the fiscal year 1970 only; and that activity for fiscal 1971 is renegotiable.

7. If any overage occurs in the program, this will be rebated to the State.

8. Every attempt shall be made to meet with other professional groups for the purpose of assisting them in their negotiations with the State, in all areas including advice as to the carrier which would be best suited to assist them in the administration of the program; and determining their premium structure.

9. Premiums will be calculated on a one-year basis, payable per person, per month; with drops adjusted on a quarterly basis; and with starts to be effective, retroactive to the first of the month in which they are authorized as a Medicaid recipient.

10. Policing of the physician portion of the Medicaid program will be handled through already existing mechanisms of the Faculty and the Commission on Medical Discipline. Where fraud exists, action shall be initiated by the State's Attorney's office both for actions against physicians, as well as those patients who might practice fraud in the program.

The Executive Committee met on February 7, 1969, and took the following actions:

1. Adopted a two-step rent increase for the State Board of Medical Examiners.

2. Acceded to a request from the Baltimore City Medical Society to permit that group's monthly meetings to be held on the first Thursday of each month. This necessitates a change in the scheduling of Executive Committee and Council meetings for 1970.

3. Visited with representatives of the State Health Department to discuss (a) mechanisms for handling complaints and investigations involving the Medicaid program (b) received statistical data in connection with the Medicaid program and requested additional information as soon as it is available (c) heard that no final decision has been made in connection with the purchase of Part B, Medicare, for Medicaid recipients who are eligible for such Part B, Medicare (d) agreed to work towards a system of peer review as quickly as possible and (e) discussed briefly the proposed formulary for use in the Medicaid program, reaffirming the Faculty's endorsement of such a system.

4. Authorized preparation of a press release containing factual data in connection with the Medicaid program, specifically insofar as 3 (b) above was concerned.

5. Heard that the Advisory Council on Mental Hygiene had decided to continue its policy of not meeting until its role and functions could be clarified; and heard that it felt this may change with the new Governor.

6. Agreed to address a letter to the Social Security Administration at Woodlawn in connection with its medical policies at the Employee Health Service; deciding that such will be referred to the Faculty's House of Delegates for action if a satisfactory reply is not received.

7. Decided that those committees which did not have recommendations for the House of Delegates need not be included in the annual reports to the House if they are not ready in sufficient time for the printer's deadline. These reports would then be made to the Semiannual Session of the House.

8. Agreed to submit the following names for the appointments shown, all made by the Governor:

   Occupational Disease Board: J. Sheldon Eastland, MD, (reappointment)
   Advisory Board on Hospital Licensure: Edmond J. McDonnell, MD, (reappointment)
   Advisory Board on Hospital Construction: Benedict Skitarelic, MD, (reappointment)
   Board of Physical Therapy Examiners: W. Grafton Hersperger, MD (to fill an unexpired term of Wetherbee Fort, MD, deceased)

9. Deferred action on submission of names of Physical Therapists for appointment by the Governor to the Board of Physical Therapy Examiners, until the March Executive Committee meeting.

10. Approved submission of the name of Harold P. Biehl, Jr., MD, for possible submission to and appointment by the Governor to the Maryland Occupational Health and Safety Advisory Board.

11. Approved meeting jointly with the Maryland Nursing Home Association Executive Committee.

12. Agreed to meet "on call" with the Maryland Hospital Council's Executive Committee.

13. Deferred action on approval of a Glaucoma Screening Project at the Social Security Administration until it could determine the medical policies at that organization (see item #6).

14. Stated it had no objection to a data gathering request from the Regional Medical Program which would ask physicians to cooperate in this area.

15. Approved the submission of one name for possible appointment to an AMA Council or Committee; and declined to do so on another name because he was neither a member of the Faculty nor the AMA.

16. Heard and discussed various legislative matters before the General Assembly.

(Continued next page)

17. Declined the use of Osler Hall for a talk on tobacco which would have been presented to pupils of School #49.

18. Declined to participate in an AMA-ERF fund raising appeal suggested by the AMA.

19. Designated John F. Schaefer, MD, to serve on an Advisory Committee of the Maryland, DC, Delaware Hospital Association to Develop Suggested Guidelines and Principles for Pharmaceutical Services.

20. Heard a request from the Maryland Society of Anesthesiologists for a representative of that group on the Blue Shield Board. Advised that group that it is impossible to have a representative of every specialty organization on the Blue Shield Board, and that in cases such as this, consultants are named. The Anesthesiology group already has a designated consultant to the Board.

21. Heard that the Workmen's Compensation Commission has declined to adopt the concept of Usual, Customary, and Reasonable Fees; and that a schedule is being developed and the Faculty will be advised when it is ready and a hearing date is set.

22. Approved a form submitted by the Maryland Medical Assistance Advisory Committee for use in transfer of patients between hospitals and extended care facilities.





DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Rehabilitation of Patients with Rheumatoid Arthritis

Rehabilitation of the patient with rheumatoid arthritis requires a comprehensive and long-term approach, preferably by a single physician. Many badly crippled patients can be helped by rehabilitation techniques, but rarely dramatically. The study of late cases suggests that many deformities could be prevented or significantly ameliorated if treatment and preventive measures had been started and continued at an earlier stage in the disease. Motivation plays a major role in the final outcome.

* * * * *

Definition

Rheumatoid arthritis is a chronic inflammatory disease of unknown origin which is systemic in nature and characterized by the manner in which it involves joints.[1-5] It runs a prolonged intermittent course, resulting in severe disability in approximately 30% of the patients. The principal cause of disability is the painful joint and the contracture and atrophy of contiguous muscles. Less frequently there is severe osteoporosis with lysis of the involved joints.

Psychiatric Aspects

Patients with rheumatoid arthritis who come to a municipal hospital are a highly selected group of older people with severe deformities and few social resources. The largest number of acute initial cases of rheumatoid arthritis occur in young females. At this time of life they are either self-supporting or supported by parents or husband. Consequently, they are seen by private doctors in private hospitals as long as they, or their relatives, can pay for private medical care.

The older patients with deforming rheumatoid arthritis are almost always victims of a prolonged, painful, gradually-limiting disease. Consequently, nearly all of them are deeply depressed, have given up hope and are frequently attached to hospital life. They are often fearful and confused. They receive information about arthritis from friends, from advertisements in magazines, and from popular medical articles. They may shift from one doctor to another, try new remedies, or move to a new part of the country in an attempt to obtain relief.

Evaluation and Treatment

Since this disease is frequently intermittent and of long duration, treatment must be carried on for long periods of time, possibly the patient's entire life. It is, therefore, important to evaluate the patient carefully when the initial diagnosis is made. Investigation of the activity and extent

of the arthritis, evaluation of functional capacity by the use of muscle tests, joint range of motion and the activities of daily living (ADL) are essential. In addition, a knowledge of the patient's psychological background and outlook, his family and social situation, and his vocational potentialities is necessary in planning management. For these reasons it is helpful to hospitalize the patient for a period of one month to six weeks early in the disease in order to perform the evaluation and determine the mode of management, as well as to educate the patient about his disease.

As for treatment, a number of drugs have proved to be of help in relieving pain in rheumatoid arthritis. Their use will not be discussed here, but any drug or modality which relieves pain promotes the maintainence of range of motion and muscle strength.

Rehabilitation

The purpose of rehabilitation in rheumatoid arthritis is 1) to relieve pain, 2) to maintain muscle strength and range of motion, and 3) to compensate for loss of range of motion and muscle strength late in the disease if severe deformities have occurred.

Relief of Pain: In addition to the use of drugs, there are several methods which are helpful in the alleviation of pain during the acute stage of rheumatoid arthritis.

Immobilization: During the acute stage, bed rest is most helpful in relieving pain. Individual joints may be immobilized by the use of splints.

Heat: Almost any type of heat will give temporary relief of pain in involved joints. When the pain is in the hands or feet the use of paraffin baths once or twice daily is often of significant value. Moist-air cabinets, Hubbard tanks, or hot baths are helpful where many joints are painful.

Maintainance of Range of Motion and Muscular Strength:

Positioning in bed: The bed should have a moderately hard mattress. A bed board is usually indicated. A soft mattress results in adduction and internal rotation of the shoulders in the supine position. Ulnar deviation of the wrists and fingers is favored when the patient's body sinks into the mattress. Pillows under the head increase the dorsal kyphosis. Pillows under the knees promote hip and knee flexion contractures. The feet should be protected from the weight of the sheets by a foot board.

Poor positioning in bed can cause irreparable damage in as little as two weeks time in some patients. Lying on the stomach several hours daily helps to prevent hip and knee flexion contractures.

Range of Motion: The patient must be taught to treat himself. Interest in this program wanes several months after the patient leaves the hospital unless rapport is established and maintained. A complete explanation of the common deformities and how they may be prevented is essential. Directions to the patient must be simple, and only the most important joints should be worked with. If a joint can be taken through the full range of motion twice daily, range of motion can be maintained.

Selective Muscle Strengthening: The muscle atrophy which is part of the disease is made worse by disuse. Efforts, therefore, should be made to maintain muscular strength in muscles crossing the most important joints. The patient should understand why he is performing the specific exercises, how often they should be performed, and exactly how to do them. The program should be performed by the patient under the direction of the physical therapist until carried out correctly. A written program should be made out individually for each patient.

Particular care should be taken to maintain motion and strength in the following joints.

Knees—Flexion and Extension: These are probably the most important joints in the body from the point of view of function in the patient with rheumatoid arthritis. Knee flexion contracture is the most common reason for forcing the patient to bed. Once patients are forced into bed, contractures of the upper extremities follow rapidly.[6]

Hips—Flexion and Extension.

Shoulders—Full elevation and abduction of the arm.

Forearms—Supination.

Wrists—Dorsiflexion, radial abduction.

Thumbs—Abduction (Abductor policies brevis) and extension.

Fingers—Index finger abduction (First dorsal interosseus).

Flexion and extension at metacarpal—phalangeal joints.[7]

Use of Splints: Splints may be used to give complete immobilization of an acutely inflammed joint. This is an effective way to relieve the swelling and pain. The fear that complete immobilization would inevitably lead to contracture has been definitely disproved.[8-10] Acutely inflamed joints may be completely immobilized in casts for as long as a month with the expectation that the joint will regain its function if appropriately treated with physical therapeutic methods on removal from the cast.

In subacute joint activity, splints which are removable several times daily or worn only at night may be effective in promoting immobilization.

Splints may also be used to prevent the gradual drifting of joints into poor position. For this purpose splints may be worn at night.

For complete immobilization, an unlined plaster cast is believed to give the maximum degree of immobilization. New plastic splints have greatly increased the strength and decreased the weight of splints so that they may be worn for months without wearing out.[11]

Serial knee splints increase range of motion in the knees, but the knees will contract into flexion again unless the patient uses the legs for walking. Dynamic or lively hand splints are effective in increasing range of motion in the fingers—if used before ankylosis or joint destruction has occurred.

Surgery in Arthritis: A large number of surgeons have become interested in rheumatoid arthritis and are rapidly gaining experience under a wide variety of circumstances in many areas of the body.[12, 13] Before undertaking reconstructive surgery in rheumatoid arthritis, it is necessary not only to know the condition of the bones, joints and muscles, but also the motivation, emotional make-up, and vocation of the patient. Even under the best conditions, recurrences of the disease may make well-performed surgical procedures useless.

The general indications for surgery are deformities which produce discomfort, loss of function, or a bad cosmetic appearance, and which cannot be corrected by non-surgical means.

Self-Help Devices: In patients with severe contractures of the back, arms or legs, a number of devices may be used which allow performance of the tasks of daily living when physical or surgical methods are not appropriate or have failed. Patients with severely contracted hips may be helped by a wheelchair. For patients who are unable to bend forward to reach the foot, gadgets to help with putting on stockings and shoes may be helpful. Patients with hip contractures may be helped by a raised toilet seat and by chairs with a slanting seat.[14]

Results of Treatment in Patients Treated at Baltimore City Hospitals

Diagnostic Group 1:

Twenty-seven patients who had rheumatoid arthritis without associated diseases were treated for six months or more. At the end of the treatment, these patients were arranged in rank order dependent on the degree of improvement they had shown in activities of daily living.

The final ranking was then compared with the ranking of a number of measurements made at initial evaluation. The Spearman Rank Correlation Coefficient (r_s) of final ranking with age when first seen was .46; the r_s of duration of illness with final ranking was .32; the r_s for initial MSCL score with final ranking was —.16; the r_s for initial ADL score with final ranking was .68; the r_s for duration of treatment with final rank was .13.

This analysis suggests that the ADL score at initial observation is the most important measurement in predicting how much a patient will improve under treatment. The higher the initial ADL score, the more likely the patient will be to show improvement in the ADL score while under treatment. The patient's age, the duration of the disease, the duration of treatment and the initial MSCL score were of decreasing importance in predicting the outcome of treatment.

Diagnostic Groups 1 and 2—Combined (Table 1 *see page 75* **):**

Of the 29 patients in this combined group, one had high blood pressure and the other mild diabetes. Table I shows that five reached full independence, two reached an ADL score of 90 to 99, and five improved slightly. Nine did not improve and eight deteriorated or died. The num-

bers are small but agree with the findings of the Spearman Rank Correlation Coefficient analysis that there is no initial finding of outstanding help in predicting whether the patient will or will not improve significantly in ADL score.

Diagnostic Group 3:

The 16 patients in this group had associated manifested disease other than rheumatoid arthritis. Five had heart disease, five had lung disease, eleven had neurological or psychiatric problems. One had osteomyelitis of the spine. This group is in no way comparable to Groups 1 and 2, since rheumatoid arthritis was often only an incidental finding. (The importance of separating patients with multiple diseases from those with only one disease has been emphasized.) Of these 16 patients, two reached full independence, two reached an ADL score of 90 to 99, one improved slightly, nine did not improve, and two deteriorated or died.

REFERENCES

1. National Foundation Conference on Rheumatoid Arthritis. *J. Chronic Dis.*, 10:365, November 1959.
2. Lowman, Edward W.: *Arthritis, General Principles, Physical Medicine and Rehabilitation.* Little, Brown and Co., Boston, 1959.
3. Short, C. L., Bauer, W. and Reynolds, W. E. *Rheumatoid Arthritis.* Harvard University Press, Cambridge, 1957.
4. Talbott, J. H. and Lockie, L. M. Progress in Arthritis. Grune and Stratton, New York, 1958.
5. Rheumatism and Arthritis. Review of American and English Literature of Recent Years, Fifteenth Rheumatism Review, *Ann. Int. Med.*, 59:Suppl. 4, Nov. 1963.
6. Kelly, M. *How to Prevent Crippling in Rheumatoid Arthritis.* Lancet 1:1158 (June 5), 1954.
7. Rose, D. L. and Kendell, H. W. Rehabilitation of Hand Function in Rheumatoid Arthritis. *JAMA* 148:1408, 1952.
8. Partridge, R. E. H. and Duthie, J. J. R. Controlled Trial of the Effect of Complete Immobilization of the Joints In Rheumatoid Arthritis. *Ann. Rheum. Dis. 22*:91, 1963.
9. Swanson, N. The Prevention and Correction of Deformity in Rheumatoid Arthritis. *Canad. M.A.J.* 75:257, 1956.
10. Kelly, M. The Correction and Prevention of Deformity in Rheumatoid Arthritis. *Canad. M.A.J.* 81:827, 1959.
11. Rotstein, J. *Simple Splinting.* W. B. Saunders Co., Phila., 1965.
12. Milch, R., Jr. *Surgery of Arthritis.* Williams and Wilkins Co., 1964.
13. Flatt, A. E. *Care of the Rheumatoid Hand.* C. B. Mosby Co., St. Louis, 1963.
14. Lowman, E. W. *Rehabilitation Monograph VI. Self-Help Devices for the Arthritic Institute of Physical Medicine and Rehabilitation.* New York University-Bellevue Medical Center.

——O——

This is the last of eleven essays on initial evaluation and prediction of performance of patients criteria for the selection of patients who may be expected to benefit from rehabilitation techniques and to judge later whether these predictions have been realized. The last two articles have illustrated the use of different statistical methods in two specific disease entities. The purpose of this series is to bring more precise methods of measurement into the field of physical rehabilitation.

——O——

RESULTS OF TREATMENT

Column		1	2	3	4	5	6
Finding at Initial Visit	Categories	Total	Reached full independence: ADL Score 100	Reached ADL Score 90-99	Reached ADL Score Less Than 90	Unchanged ADL Score	Deteriorated in ADL Score or Died
Cases		29	5	2	5	9	8
Age:	59 or less	20	3	2	4	6	5
	60-69	5	2		1		2
	70-79	2				2	
	80 +	2				1	1
Male		12	2	1	3	4	2
Female		17	3	1	2	5	6
Duration at Initial Visit	Less than 1 year	3	1			1	1
	1 to 5 years	10	2	2		5	1
	6 to 10 years	5				1	4
	11 to 20 years	5	2		1	2	
	21 + years	4			3		1
	unknown	2			1		1
Initial MSCL Score	0-10						
	11-20						
	21-30					1	1
	31-40	10	2	1	2	3	2
	41-50	11	1		2	3	5
MSCL not performed		6					
Initial ADL Score	0-20	1					
	21-40	9	1		4	3	1
	41-60	5	1	1		2	1
	61-80	3	1	1			1
	81-95	7	2		1	3	1
	96-100	4				1	3
Diagnostic Group	1	27	5		5	8	8
	2	2		1		1	
Duration of Treatment	6 mos to 1 yr	7	2		3	2	
	1 to 2 years	1					1(d*)
	2 to 3 years	7		1		3	3(1d*)
	3 to 4 years	6	2		1	2	1
	4 to 5 years	4		1	1	1	1(d*)
	5 to 6 years	3	1				2(1d*)
	6 years +	1				1	

TABLE 1. 29 patients with Rheumatoid Arthritis in Diagnostic Groups 1 & 2, treated more than 6 months.

* d = died

MERCEDES-BENZ

Baltimore's only Authorized Dealer for Sales, Service and Parts

R. & H. Motors, Inc.

4810 Belair Rd. 426-9200

Baltimore, Md. 21206

MANUEL SCHWARTZ

HEARING REHABILITATION

802 Medical Arts Bldg. Phone: 685-4898

BALTIMORE, MARYLAND 21201

DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION

Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

Visit the #1 Spot for Your Diet Needs

Now in our new location

1 No. Howard St.

(Corner of Baltimore St.)

For the Food Your Doctor Advises

● Low Sodium ● Sugar-free ● Non-allergic

SPECIAL DIET SHOP

Phone SA 7-0383

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery MU 5-3232

D. Stuart Webb

Advertising Services, Inc.

306 N. Gay Street Baltimore, Md. 21202

DRINK MORE MILK
for your health sake



- More Vitamins
- More Minerals
- More Energy



Deliveries in Maryland, Washington, and Virginia.

Life Begins With Embassy Milk

EMBASSY DAIRY
DU 7-1441

1620 First St. N.W.
Washington, D. C.

SAVE 5%

Bring this Ad and save 5% on your initial purchase of Nursery Stock. Void after May 15, 1969

WE SPECIALIZE IN:

AZALEAS
RHODODENDRONS
JAPANESE HOLLIES
YEWS
FLOWERING SHRUBS
FLOWERING TREES
FRUIT TREES
GROUND COVERS

SEE OUR FAMOUS COUNTRY STORE

Valley View Farms

COUNTRY STORE

York Road Cockeysville, Md.

666-2058

¼ mile north of Underpass on the right

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

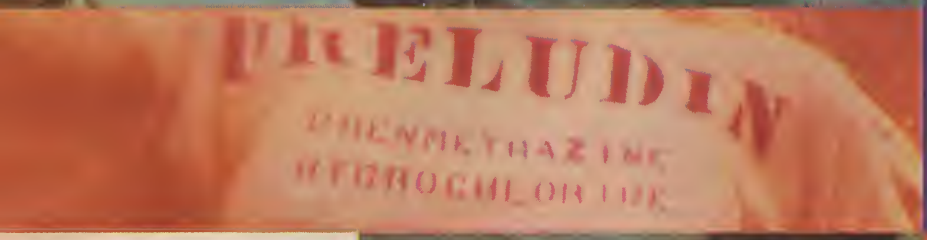
Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.













Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000. Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B) R3-46-560-B

Under license from Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

Preludin® Endurets®
phenmetrazine hydrochloride prolonged-action tablets



They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a natural curb on appetite and frequently promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CN depressants. As with all CNS-acting drugs, ca tion patients against hazardous occupations r quiring complete mental alertness (*e.g.*, operati machinery, driving). Though physical and ps chological dependence have rarely been report on recommended doses, use caution in a ministering Librium (chlordiazepoxide hydr chloride) to known addiction-prone individua or those who might increase dosage; withdraw symptoms (including convulsions), followi discontinuation of the drug and similar to tho seen with barbiturates, have been reported. U of any drug in pregnancy, lactation, or in wom of childbearing age requires that its potenti benefits be weighed against its possible hazar As with all anticholinergic drugs, an inhibiti effect on lactation may occur.

PRECAUTIONS: In elderly and debilitate limit dosage to smallest effective amount to pr clude development of ataxia, oversedation confusion (not more than two capsules per d initially; increase gradually as needed and tole

or here.



ated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Public Enema No. 1





Claim the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

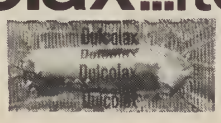
Compared to enemas, Dulcolax suppositories are a gentler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. Just one suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes to an hour.

In the hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl



Under license from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

DU-

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City
health department

BALTIMORE'S HEALTH IN 1968

In a review of health conditions during 1968 in Baltimore city prepared by Matthew Tayback, ScD, Deputy Commissioner of Health, the most important developments noted were:

1. **Remarkable control of those diseases for which vaccines exist to prevent illness**
2. **Extensive illness from acute respiratory conditions for which preventive procedures are limited**
3. **Measurable progress in the fight against tuberculosis**
4. **A determined effort by the City Administration to improve the sanitary level of the residential areas of the City**

Two extensive outbreaks of acute respiratory illness, one in late January, and the other in December due to Hong Kong type influenza, probably caused 1,000,000 days of disabling illness among residents of Baltimore city. Diseases similar in means of transmission (diphtheria-0, whooping cough-23, poliomyelitis-0, and measles-66) in total caused less than 1,000 days of illness. This striking difference is due to the availability of preventive vaccines and to the protective inoculation service and health intelligence systems evolved and maintained by the City Health Department. One may confidently expect that within the near future, vaccines of high potency against the many viruses which cause acute respiratory disease will help reduce the enormous extent of illness caused by these conditions as well as the cost in lost time and in medical care.

In order to understand the nature of health problems in the City one requires detailed knowledge of the characteristics of the population. The latest revised estimates have been made and conform within 1% to the independent calculations of the U.S. Bureau of the Census. Revised population estimates for Baltimore city for the past two years are:

Year	Total	White	Nonwhite
1968 (July)	918,000	505,000	413,000
1967	930,000	523,000	407,000

There is continuing evidence of considerable migration within and in and out of the City. These movements are important not only because they are resulting in marked changes in the social and economic characteristics of the City's population, but also because increasing numbers of our residents are moving to neighborhoods where added social and health services should be provided. In this regard the City Health Department is readjusting its clinics and services to meet the changing needs inherent in the population trends.

Tuberculosis

Tuberculosis is one of the more difficult public health problems which has engaged the attention

of many skilled professionals in Baltimore city. During 1968, the number of newly reported active cases was 640, a reduction of 6.7% from the level of 683 reported in 1967. Although the incidence of tuberculosis in the City is relatively high (70 new cases per 100,000 population) studies of the spread of infection indicate that transmission of tuberculosis is rarely seen among middle-income and upper-income families and that even among the children from economically deprived circumstances, spread of infection is at a remarkably low level. The high level of cases among adults largely is the result of a breakdown in the health of adults infected many years ago with tuberculosis rather than the result of a recent tuberculosis infection. Aside from the economic improvement of low-income families, the Department's continuing control of active infectious cases and the newly established preventive procedures of identifying and treating dormant tuberculosis will be the chief elements protecting the population from this disease.

Maternal and Child Health

Although widely removed from tuberculosis as a health problem, the health of mothers and children is determined by the same factors, namely, social stability, economic support, and availability of adequate medical services. Steady decline in the infant mortality rate over the past six years, from 32.5 infant deaths per 1,000 live births for the two-year period 1961-1962 to 27.6 for the biennium 1967-1968, a 15% reduction, is an indication of the progress being made in this problem area. Substantial further progress could be made in the reduction of infant mortality, if child-spacing patterns could be improved.

Baltimore continues to have a difficult problem in the occurrence of approximately 1,000 live births among unmarried girls under 17 years of age. The City Health Department with the financial assistance of the Thomas Wilson Sanitarium Fund has launched two experimental programs to contend with this problem. One, in cooperation with the Maryland League of Women's Clubs is concerned with improving the social environment of young adolescent girls and provides health education and counseling to encourage sound family-life patterns. The second, in cooperation with Sinai Hospital, provides medical services to assist adolescent girls with family planning when these youngsters, with the consent of their parents, seek such help. These efforts are unique and need considerable further reinforcement and financial support if the City is determined to solve a problem which leads to a myriad of subsequent social, economic and medical difficulties.

An examination of the birth statistics for 1968 shows a substantial further decline in the number of live births among City residents. The total of 16,825 resident births in 1968 is the lowest such figures since 1941. It is 6% below that for 1967 and 28% below the total of 23,262 registered in 1960. These are truly phenomenal changes and by and large will result in considerable reduction in the volume of service required of facilities which deal with young children. The sharp drop in live births has come about as a result of a tendency to smaller families, particularly among low-income groups to whom non-availability of birth control methods prior to 1963 resulted in families larger than those desired. The City Health Department family planning clinics and those operated by Planned Parenthood, as well as the special efforts of the departments of obstetrics of several of the major hospitals, have been the prime factor in achieving this striking and highly desirable change.

As a result of declining fertility, but also as a result of substantial movement of young families out of the City, there is a situation in the white segment of the population which has not occurred previously in the recent recorded history of our community. The number of deaths exceed the number of births. This is indicative of a population segment in which the older age groups are predominant. As a result we are faced with rapidly burgeoning requests for medical and social services to elderly residents whose numbers increase rapidly while, in the white community, the number of children and young adults decline appreciably. During 1968, for example, there were 7,338 deaths among white residents while the number of births was 7,235. By contrast, a more conventional situation was noted in the nonwhite segment of the City's population in which there were 9,590 births and 4,308 deaths contributing to a population increase of 1.3% in this segment.

Among preschool-age children, the chief problems which engaged the attention of health services were those which were seen particularly among families in deprived economic conditions, namely, impaired physical development due to poor nutrition, below-average intellectual development due to inadequate environmental stimula-

tion, and the inaccessibility of satisfactory medical services. In the latter regard, it was apparent that the resources available for medical care of families with limited economic circumstances were being strained to the breaking point, and that two issues would need immediate solution if further difficulties were to be avoided, *ie,* (1) sufficient financing of medical care for all families with low income, and (2) organization of systems of care which use funds efficiently to reach families with medical services which are accessible and understandable. The City Health Department is now engaged in the development of plans to be submitted to the Mayor which, it is hoped, will accelerate a solution of this issue.

Environmental Health

While the City draws its strength from its distinctive position as an industrial and commercial center and as a focus for cultural and university life, it is under increasing pressure to prevent deterioration of its environment. The City Health Department increased its efforts to improve the quality of the air by banning open-air burning. In addition, with a grant from the Federal Government, it launched a vast program of rat eradication, while also assuming a new responsibility for a corps of Sanitary Enforcement Officers.

The end effect of all health services is the preservation of life and the provision of comfort and security of person. For several years, it has been most disturbing to note the steady loss in life due to homicide. In 1968, a further 32% increase in the number of homicides was recorded. Within the past nine years the homicide trend is as shown below.

Year	Deaths	Year	Deaths	Year	Deaths
1960	106	1963	140	1966	185
1961	90	1964	125	1967	205
1962	105	1965	137	1968	267

This increase cannot be attributed to a change in record-keeping practices as the totals for each year are based on certifications made by the medical examiner using standard procedures. A joint attack on this problem by legal, police, and health authorities would appear necessary to stem further increase in the loss of life due to homicide.

Concluding Note

In reviewing our major health problems one gains a sense of optimism when the extent of progress and accomplishment during the past six years is assessed. Among some of the major achievements are:

1. Near eradication of two diseases—poliomyelitis and measles.
2. Vast expansion of services for mothers and infant children resulting in the availability and acceptance of family-planning methods by thousands of mothers from the inner city and in a significant reduction of infant mortality among their babies.
3. Creation of comprehensive health centers for 20,000 children and youth.
4. Increased efforts for the control of atmospheric pollution.
5. Successful establishment of psychiatric services for adults including the creation of an Alcoholism Center.
6. Initiation of experimental programs to solve the difficult and fundamental problem of teen-age pregnancy.
7. A four-fold increase in rodent control work leading to prospects of rodent eradication.
8. Creation of a social-medical service for the care of disabled aged persons residing in their own homes.

These are massive efforts resulting from aggressive leadership and represent significant health gains. The next challenge will be to continue the efforts to organize Baltimore's many health services so that the individual and the family unit can receive the optimum benefits of medical skill and knowledge in a manner which will provide a source of comfort and personal motivation to better health.

(See the following page for the Provisional Report of Vital Statistics for 1968)

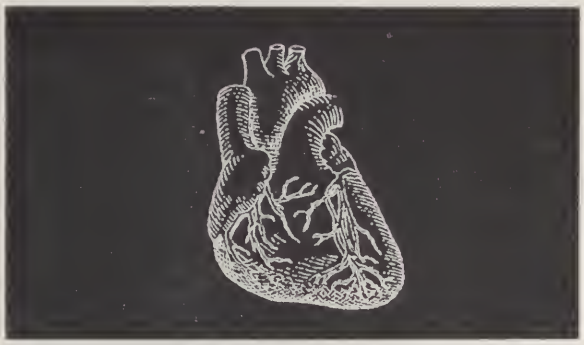
PROVISIONAL REPORT OF VITAL STATISTICS FOR 1968

		Provisional Figures, 1968			Final Figures, 1967		
		Recorded	Resident		Recorded	Resident	
			Number	Rate *		Number	Rate *
Births:	Total....	25,144	16,825	18.3	26,518	17,985	19.3
	White....	15,037	7,235	14.3	16,185	8,212	15.7
	Nonwhite....	10,107	9,590	23.2	10,333	9,773	24.0
Deaths:	Total....	13,410	11,646	12.7	12,808	11,201	12.0
	White....	9,162	7,338	14.5	9,070	7,407	14.1
	Nonwhite....	4,248	4,308	10.4	3,738	3,794	9.3
Infant Deaths:	Total....	665	477	28.4	698	472	26.2
	White....	314	143	19.8	375	177	21.6
	Nonwhite....	351	334	34.8	323	295	30.2

* Birth and death rates per 1,000 population: Infant mortality rates per 1,000 live births.

	Cases		Resident Deaths	
	1968	1967	1968	1967
Total	11,903*	11,737	11,646	11,201
REPORTABLE DISEASES				
Chickenpox	358	441	1	0
Diarrhea & enteritis	6	6	6	9
Diphtheria	0	0	0	0
Dysentery	25	85	0	0
Encephalitis (acute infectious)	4	264**	0	0
German measles	132	110	0	0
Hepatitis, infectious	326	416	7	2
Measles	66	92	0	0
Meningococcal infections	18	18	6	4
Mumps	496	612	0	0
Poliomyelitis (paralytic)	0	1	0	0
Scarlet fever	44	98	0	0
Smallpox	0	0	0	0
Streptococcal sore throat	53	38	0	0
Tetanus	0	0	0	0
Tuberculosis (active)	640	683	105	110
Typhoid fever	3	1	0	0
Undulant fever	0	0	0	0
Venereal diseases				
Syphilis	1,726	1,648	11	13
Gonorrhea	7,236	6,762	0	2
Whooping cough	23	25	0	0
OTHER CAUSES OF DEATH				
Accidental causes			485	510
Home			148	152
Occupational			40	25
Motor Vehicle			177	186
Other public			120	147
Cancer			1,977	1,945
Cerebral hemorrhage			919	858
Cirrhosis of liver			350	302
Congenital malformations and diseases of early infancy			343	413
Diabetes mellitus			414	324
Heart disease			4,510	4,482
Homicides			267	205
Influenza			7	2
Nephritis			57	71
Pneumonia			470	380
Puerperal causes			8	8
Suicides			101	82
Other specified causes			1,602	1,479

* Includes other reportable diseases: 515 cases in 1968 and 432 in 1967.
** In 1967 included aseptic meningitis.



JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Recognizing the Acute Coronary Process

If we are to prevent needless death and minimize disability resulting from heart attacks, we must stop trying to diagnose the wrong condition. The emphasis must shift from the detection of myocardial infarction to the suspicion of an "acute coronary process." The danger to life in acute coronary disease arises not so much from myocardial necrosis as it does from acute myocardial ischemia. Most deaths in heart attacks stem from the acute effects of myocardial ischemia (arrhythmia, shock, and failure), rather than from the more chronic results of myocardial necrosis (heart failure, myocardial rupture, and embolism). The patient who recovers from a heart attack with myocardial infarction, an abnormal electrocardiogram, and no angina will live longer and more comfortably than the one who recovers without evidence of myocardial infarction and with a normal resting electrocardiogram, but with angina. Pathologically, this latter group is comprised of "the hearts too good to die." Autopsy often shows not only no recent myocardial necrosis, but frequently not even a recent coronary thrombosis is recognizable.

SIDNEY SCHERLIS, MD

Assistant Professor of Medicine
University of Maryland School of Medicine

Approximately one-quarter of sudden deaths, attributable to coronary artery disease, occurs in persons who have had recent symptoms which were either not recognized or not suspected of being cardiac in origin. Similarly, it has been shown that about 20-25% of patients recognized in periodic examinations to have myocardial infarction, either had no cardiac symptoms, or were not recognized as having coronary disease when they did consult their physicians. These so-called "silent coronaries" too often, I believe, are not so much silent as they are unrecognized. The emphasis, therefore, must be placed not on confirmation of the myocardial damage resulting from interference with coronary blood flow, but on the suspicion that the coronary circulation is being compromised before complications occur.

One need not be a diagnostician to suspect that a patient with severe constrictive chest pain, shock, or heart failure, may have coronary artery disease. Nor is particular astuteness required to conclude that a patient with a grossly abnormal electrocardiogram may have myocardial infarction, especially if serum enzyme tests (SGOT, SLDH, SCPK) are abnormal. This, however, is "closing the barn door after the horse has escaped." Vascular surgeons would not view a colleague with approbation who prides himself upon making a diagnosis of peripheral arterial embolism by waiting for necrosis of the distal portion of the limb

to occur. Neurologists no longer wait for a stroke to appear before attempting to diagnose it or treat the patient who has symptoms suggestive of cerebral vascular insufficiency.

Before discussing the problems and principles involved in the early detection of an acute coronary process, one might ask whether there is any evidence of the fact that such early recognition does benefit the patient. In other words, is there treatment which will either prevent sudden death, or minimize the extent of the possibly ensuing myocardial infarction? I believe that the widespread experience in coronary care units demonstrates beyond question the efficacy of early careful observation and treatment in decreasing the incidence of early death in patients with acute coronary disease. Although it is less readily proved that early treatment helps prevent myocardial necrosis, it does seem quite likely that a heart muscle whose coronary circulation is obstructed will probably suffer less necrosis if fewer demands are placed upon it until its anastomotic circulation has had an opportunity to develop.

In order to facilitate detection and promote treatment, it is necessary to know how often premonitory symptoms occur. The frequency varies in reported series from 30% to 80%. In my own experience, the patient with acute myocardial infarction, who previously has not had symptoms suggestive of coronary disease for days, weeks, or even months, does exist. He is such a rarity that I doubt either my skill in asking the proper questions, or the patient's ability to recall earlier events to prompt diagnosis. When one is dealing with early clinical manifestations of coronary artery disease, there is no substitute for a painstaking history. Often, in the busy emergency room, the patient is questioned about acute complaints and is subsequently admitted to the hospital for treatment. As a result, the opportunity to learn about the early clinical manifestations of the disease is ignored.

In this discussion, the term "acute coronary process" is used rather than "acute coronary thrombosis", or "acute coronary occlusion", because we are not all in agreement regarding the early pathological and physiological changes which convert long-standing, slowly-progressive atherosclerosis to an acute, rapidly-progressive process, which, all too frequently, results in myocardial infarction or death or both.

Clinically, the acute coronary process is frequently identifiable not only retrospectively, but prospectively. In its recognition lies greater promise in the immediate future for preventing death and disability due to heart disease, than the more widespread application of electrocardiography and other laboratory procedures. In fact, many lives might well be saved if the physician, who suspects an acute coronary process, were to rely on his suspicions as the basis for treatment, rather than on an electrocardiogram that might be normal, or not characteristically abnormal at that time.

The symptoms of the acute coronary process are the result of interference with the coronary arterial circulation. The most common complaint is pain. Some patients deny pain but admit to "discomfort", "a strange feeling", or "indigestion". The sensation usually differs from anything that the patient has experienced before, and may be distressing or alarming. It is usually located in the anterior chest, in the central retrosternal area, or across the upper chest. Localized parasternal or costochondral discomfort is usually not cardiac in origin. The discomfort of the acute coronary process which is pressing, constricting, or burning in quality, gradually increases, and then decreases in intensity. Ordinarily, sharp, stabbing pains are not due to an acute coronary process. The coronary pain is not maximum at onset, nor is it related to respiration. It may radiate to the neck, jaw, teeth, ears, arms, abdomen, or back. At times, the secondary areas are more severely affected, and there may be little or no chest pain. The discomfort may be intermittent and inconsistent. It may last for minutes or hours, and usually varies in severity if it is of long duration. Possibly, it may be related to physical activity, emotional stress, exposure to cold, straining at stool, or may occur after a large meal. The patient may feel perfectly well between the episodes, while engaging in normal activities.

Instead of pain, the patient suffering from an acute coronary process may have a pain equivalent—dyspnea, light-headedness, weakness, or a sense of heaviness in the arms. The sudden occurrence of an arrhythmia, heart failure, or anginal pain in a patient who has no previous history of coronary disease, should suggest the possibility of an acute coronary process. Syncope, sudden profuse sweating, or shock may have similar significance.

However, not all patients with chest discomfort have coronary heart disease. Pulmonary embolism, pericarditis, pleurisy, esophageal-hiatal hernia, gallbladder disease, peptic ulcer, cervical

arthritis, and costochondral arthritis may all produce symptoms similar to those of coronary disease. The fact is, nevertheless, that patients with the symptoms described should be suspected of having an acute coronary process and should be treated accordingly, until proved otherwise. At the appropriate time, tests to substantiate this or other diagnoses may be undertaken.

The physical examination may not be helpful diagnostically at this time. The patient may appear well, especially if the discomfort has gone. The heart sounds may be strong, the blood pressure normal, and the lungs clear. If the heart sounds are of poor quality, the heart rhythm abnormal, or the lungs congested, then, of course, heart disease is more likely to be present. If the physical examination reveals no abnormal cardiac findings, the patient still must be treated on the basis of the suspicion of an acute coronary process.

The electrocardiogram may not be abnormal, because the interference with the coronary circulation may not be extensive enough, nor of sufficient duration, to produce myocardial necrosis or ischemia that will affect the electrocardiogram appreciably. On the other hand, diagnostic changes may be present in the electrocardiogram early, or, frequently, they may not appear for hours or days. A changing electrocardiographic pattern is indicative of an acute process, whether or not the abnormalities are typical or extensive. If electrocardiographic abnormalities do not appear, it is possible that the suspicion of an acute coronray process was wrong, or that the treatment was effective in preventing detectable myocardial damage. Such patients may later have clinically recognizable angina pectoris, or exercise tests three to six months later (not earlier) may reveal abnormal electrocardiographic responses.

In the absence of these electrocardiographic abnormalities, serum-enzyme studies, intended to support the suspicion of myocardial necrosis (SGOT, SLDH, SCPK), are rarely of help. They are useful in dealing with a patient whose electrocardiogram is an unchanging one for other reasons, such as, a patient with left-bundle branch block.

This paper, then, is a plea to shift the emphasis from *recognition* of the *ravages* of coronary artery disease, as manifested by myocardial infarction, to *suspicion* and *detection* of the *earlier incipient stages* of the acute coronary process, when the fruits of discovery are so much greater.

SKIN PROBLEMS

Caused by itching due to:



Dry Eczema	Acne
Chafing	Ivy Poisoning
Minor Burns	Cold Sores
Athlete's Foot	Heat Rash
Dry Skin	Diaper Rash
Wind Burn	Chapping
Insect Stings	Hemorrhoids

For Safe, Sure, Speedy Relief —
— Get RESINOL GREASELESS!

Medical Scientists have conquered 6 dread diseases in the past decade, but they are largely in the dark, they admit, in finding relief for one age-old ailment—itching



New remedies containing antibiotics have been tested, but have often caused side effects which are worse than itching skin. After many years of research and testing, Resinol Greaseless Cream was developed. . . . A doctor's formula containing safe yet powerful ingredients, Resinol Greaseless contains an amazing, proven "anti-itch" medication called Resorcin, which quickly and effectively relieves most any kind of itching. Try Resinol Greaseless . . . You'll be delighted to find that it really works! At all drug stores. Buy a tube today.

Family First Aid in a Tube Carry in Purse or Pocket A Medicine Cabinet "Must"

"Resinol Really Works"

RESINOL CHEMICAL COMPANY
517 W. Lombard St.
Baltimore, Md. 21201



Legs don't come in exact sizes

No two legs are alike . . . not even on the same patient, and the usual "small, medium and large" sizes of elastic stockings will not be effective for the majority of your patients.

That's why *Jobst Venous Pressure Gradient*® supports are custom-made, and precisely fitted to the individual patient with a long series of careful measurements.

Even more *important* than the perfect fit, are the *exact* counterpressures built-in to your own prescription!

Jobst Venous Pressure Gradient® elastic stockings are a treatment of *choice* for leg ulcers, varicose veins, stasis dermatitis, postmastectomy lymphedema, post-phlebitis syndrome, post-fracture, post-operative and injury edema.

For full information, have your secretary mail the coupon below. Or if you have an immediate problem, just call the number on the coupon. You will find out why we named them "Service" Centers.

Jobst Service Center,

Suite 200, 818 Eighteenth Street, N.W.
Washington 20006, Phone (202) 298-5530

Suite 415, Medical Arts Bldg., 101 W. Read St.
Baltimore 21201, Phone (301) 539-0560

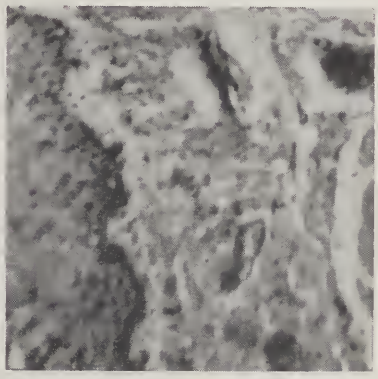


NAME _____

INSTITUTION _____

ADDRESS _____

CITY, STATE, ZIP _____



JOHN E. ADAMS, MD, EDITOR

pathology

Community Blood Resource Program

The need for a broad based, controlled, and easily researched inventory of the total community blood resource has been evident with blood bankers almost since the advent of blood transfusion therapy. Past and current methods of blood procurement are inefficient, have not changed appreciably in decades, and have not kept pace with the giant steps in immunohematology and transfusion therapy. Technical methodology of transfusion therapy has advanced while administrative methodology to complement these vastly improved technics have lagged far behind and beg to be updated.

Described below is a concept for a program of inventory and control of the total community blood resource. The purpose of this report is to disseminate and test the idea, and to stimulate interest and cooperation, both of which are mandatory for the successful institution of such a program.

The purpose of the program is to provide a comprehensive, current and readily accessible cumulative file of all blood resources in the community, including walking donors, frozen blood, fresh and frozen blood components, rare blood types and whole blood stocks. Such a program would provide a significant contribution to the efficient meeting of community health needs in the area of blood transfusion therapy. By sharing resources, by standardizing procurement methods and by decreasing outdating of blood, such a program would enable the community to supply better the blood needs of its patients.

A program of this sort presents a large administrative problem involving storage and manipulation of large amounts of specific data. However, since this problem is similar to administrative problems common to all blood banks, shared methods are feasible and economy can be expected. A properly organized, computer-supported system can provide this total community blood resource inventory and control. Data storage for the predictable future is not so massive and manipulation is not so complex that a large computer dedicated solely to this project is necesary. The program can be handled by a medium-size, fast, third generation computer on a time shared basis while the same computer is serving other needs and purposes.

A flow chart which condenses and illustrates the salient features of the program is shown in Figure 1. Numerals in the chart refer to subsequent explanatory paragraphs.

(see next page for Figure 1)

(1) The program can accommodate any number of hospitals. The connecting link between the central computer facility and each participating hospital is a teleprocessing terminal. One terminal with keyboard entry and a character printer providing hard copy for audit trail is strategically placed in each hospital. All data

concerning current blood stocks, donors, assurance programs, and patient blood needs are processed rapidly and easily using this terminal. The American Red Cross is an integral part of the program since its resources represent a major portion of the community's total blood resource. The inventory of the Red Cross is entered and continuously updated using this same terminal. Virtually all administrative records of each blood bank are kept in the central facility, including all donor and recipient debit and credit records and the status of all blood, including its condition, characteristics, source, and shelf life. Records that are appropriate only for the use of the individual blood bank can be sequestered to assure use only by that blood bank.

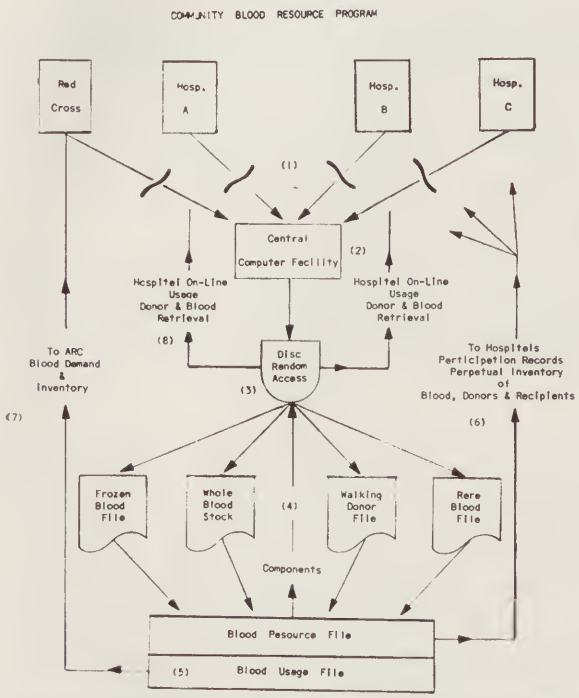


Figure 1—Community Blood Resource Program-Flow Chart

(2) The central computer facility is a portion of a third generation computer. The blood resource program has its own manager, the equivalent of a systems engineer, with supervisory responsibilities for maintenance of the program. The central processing unit of the computer and other peripheral equipment are shared. The additional unshared hardware required at the central facility is one or more disc drive units, depending upon the number of participants.

(3) In such a program random or direct access capability is required for on-line continuous data entry, correlation, and retrieval from all files. Twenty-four hour operation is mandatory and can be arranged with an acceptable increase in overhead expense.

(4) The files shown are examples of data base organization and are not intended to be all inclusive or exclusive of other files. Utilizing appropriate computer programs, the entire data base representing the community blood resource is entered into these files, properly organized and assimilated for utilization as information retrieval. For example, in a type-specific blood assurance program consisting of a preprocessed walking donor file, the recording of preprocessed donors, including blood group and type, serology, antibodies, address, telephone number, and hours of availability constitutes the data base for this file. Retrieval according to specific patient need comes through access to this file and other files (see paragraph 8).

(5) Major correlative files are compiled from individual blood procurement and usage records, and provide records of donor and recipient transactions and hospital participation for individual hospitals. This file also represents the total current community blood resource at any time. Since all donors are listed in the file, together with any characteristics, such as, a history or physical condition that would preclude donation, donors can be cleared for acceptability through the computer prior to phlebotomy. The computer can also help to search for hepatitis carriers by flagging all donors involved in a hepatitis case. A donor involved in two or three cases of post-transfusion hepatitis then can be listed in the computer as unacceptable as a continuing donor.

(6) Monthly usage reports are provided to individual hospital participants. All hospital assurance program records, together with the records of the current status of donors and recipients and individual blood bank statistics, are kept in these files. Automatic notification of donors and recipients by letter is readily available and serves several purposes. For example, yearly queries to donors for change in status or location are advisable for file up-

dating. Similarly, automatic notification of a donation requirement and automatic acknowledgement of a donation are useful. Equally effective are automatic queries to patients and their families requesting replacement for outstanding blood indebtedness.

(7) Daily reports to the Red Cross show the current status of the total community blood resource as well as a prediction of the blood need for the immediate future. Based on today's total blood resource, a prediction as to tomorrow's blood need is made and reported to the Red Cross which gears its phlebotomy activities accordingly. Further, through comprehensive inventory and usage prediction, blood of specific type that is known to be overstocked is immediately processed into frozen blood stock, eliminating the risk of outdating.

(8) With the total community blood resource compiled, organized and retrievable from a central file, the program provides the best source of any specific requirement at any time of the day or night upon request. An inquiry into the system by a participant hospital stimulates a computer search of all files to provide the most suitable blood product from the best location within the community at the time of the request. The computer evaluates whether a specific blood request can be provided from current whole blood stocks, frozen blood stocks or a walking donor file, or whether the specific need cannot be met from within the community. For example, inquiry using the hospital terminal for a specific blood need is made. The computer reports the most readily accessible supply of suitable characteristics or the most suitable and accessible assurance program donor at the time of day the request is made, considering not only the hours of availability of the donor but his geographic location with respect to the requesting hospital. All of this information is available rapidly in response to the individual hospital inquiry; the inquiry and response are provided through the same terminal that is used for data input.

The cost of such a program after the development phase and with the participation of a sufficient number of hospitals has not been determined exactly at this time, but estimates show that the cost can be predicted to be within the reach of, and economically feasible for most blood banks. Because the majority of each blood bank's administrative work load is absorbed by the system, the saving in administrative work load should pay at least for the individual blood bank's teleprocessing terminal. Per unit cost of blood procurement today probably ranges between $10 and $50 depending upon conditions. Significant savings can be realized by computer control to reduce the per unit procurement cost to a minimum in each case as illustrated above. Outdating ranges between 4% and 15% in the average hospital in this area. When translated into dollar loss that can be avoided by computer control, such savings can go a long way toward amortizing the cost of participation in the program. For example, if a hospital uses 3,000 units of blood per year and outdates 300 units at $10 per unit procurement cost, the hospital possibly has already spent more in outdated blood than the cost of participation in the program. The patient is the equal beneficiary since the cost of transfusion therapy is reduced proportionally and significantly, and the patient receives a therapeutic agent that is best suited to his needs, more rapidly and at reduced cost.

Problems incident to the establishment of such a program are formidable and certainly will center about the stimulation of interest and participation of the majority of the major blood users in the community. Rules for acceptable levels of participation would be necessary and some uniformity in blood processing and data entry are essential so that all blood listed on the inventory is of approximately equal status. Since quality in blood banking has been standardized through the various inspection and licensure programs, uniform quality is relatively easy to attain, but the definition of quality and the participation level would seem to be an essential feature of the program. The outlook should be optimistic, however, if one can use past experience in this community as a criterion. For example, other cooperative community blood programs which depend largely upon cooperative effort, such as PULSE and the Maryland Blood Exchange, have been successful. In spite of the obvious problems, it would seem that altruism can prevail and success can be the result. The goal of better, more economical blood provided to the patient more rapidly will make the attainment worth the effort.



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.



Roche
LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

We lease car,

not cars (plural). Car (singular). When a professional man like you wants just one car.

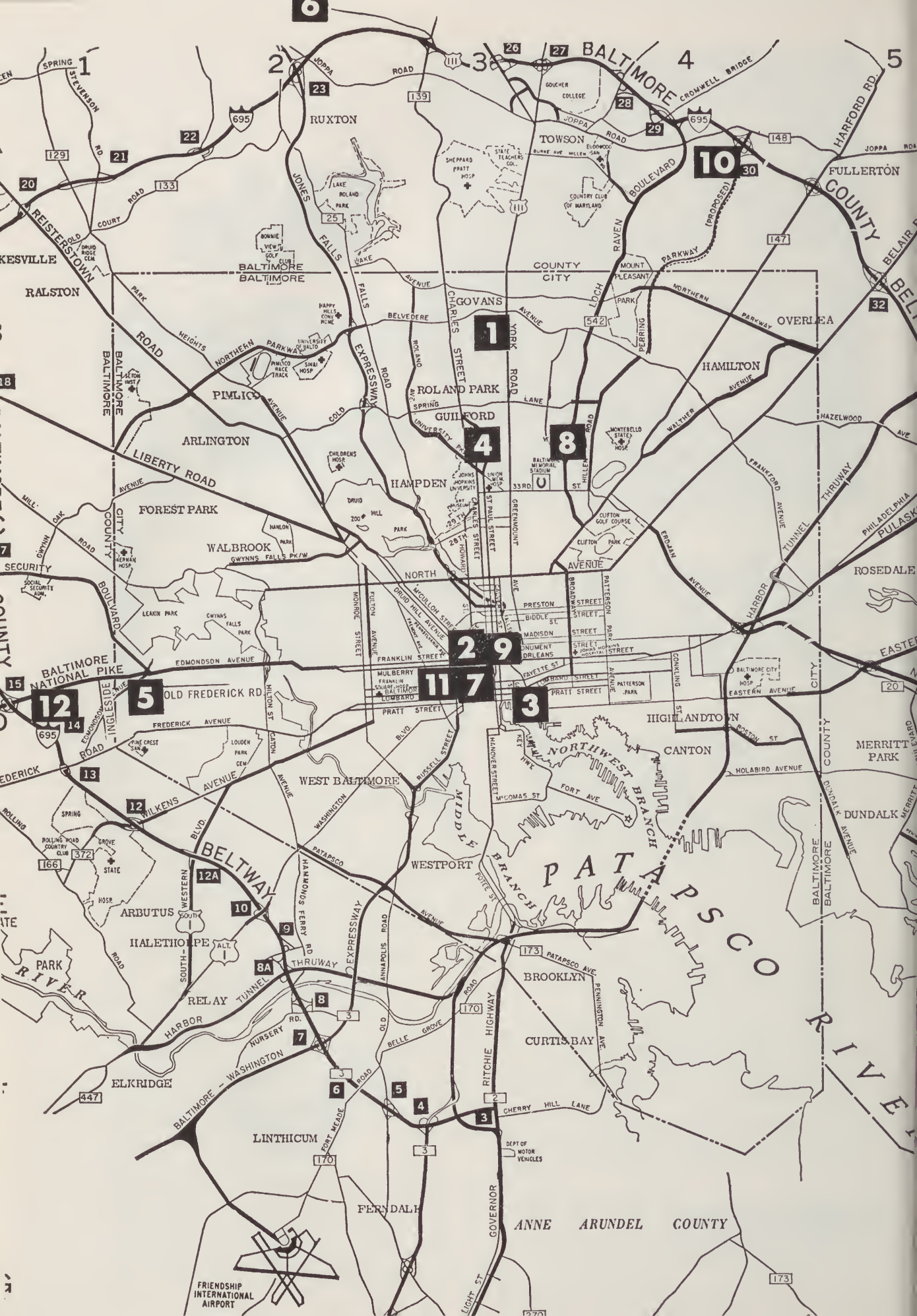
We do one-car-at-a-time leasing with plans particularly appropriate for the professional man. Plans designed to give you the same advantages as enjoyed by big companies that lease.

These advantages include: the new '69 you want as you want it, no capital tied down in a depreciating asset, no separate maintenance or insurance bills, convenient service without extra charge at thousands of "Happy Motoring"® stations throughout the United States, exact transportation costs records on a single monthly bill for tax accounting, no trade-in problems or losses.

Many physicians and surgeons are now leasing. With good reason. Ask your nurse or secretary to drop us a note, or call us, for a detailed booklet explaining the Humble Leasing Plan.

HUMBLE LEASING COMPANY
457 Central Avenue
Newark, New Jersey 07107
Telephone: (301) 837-4510




BALTIMORE
RUXTON
TOWSON
FULLERTON
RALSTON
GOVANS
OVERLEA
HAMILTON
ROLAND PARK
GUILFORD
ARLINGTON
HAMPDEN
FOREST PARK
WALBROOK
NORTH
ROSEDALE
HIGHLANDTOWN
CANTON
MERRITT PARK
DUNDALK
WEST BALTIMORE
WESTPORT
NORTHWEST BRANCH
PATAPSCO RIVER
BROOKLYN
CURTIS BAY
ELKRIDGE
LINTHICUM
FERNDALE
ANNE ARUNDEL COUNTY
ARBUTUS
HALETHORPE
RELAY
PARK RIVER
BELTWAY
LIBERTY ROAD
REISTERSTOWN ROAD
YORK ROAD
CHARLES STREET
FALLS ROAD
HARFORD ROAD
JOPPA ROAD
BALTIMORE NATIONAL PIKE
EDMONDSON AVENUE
FREDERICK AVENUE
OLD FREDERICK RD
PRATT STREET
BALTIMORE COUNTY
FRIENDSHIP INTERNATIONAL AIRPORT

Restaurants of Distinction

Locations indicated by numbers on map

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

ltimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center

Open 12 noon to 3 A.M.—Closed Mondays

For Reservations Call 685-2811

2 blocks south of the Flag House

300 ALBEMARLE STREET

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE

Baltimore 1, Md. MU 5-6790

CARRY-OUT SERVICE

SPECIAL LUNCHEON and DINNERS

PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.

Sunday 12 Noon to 3 A.M.

Cork 'n Bottle Restaurant

EAK — SEAFOOD — PRIME RIB

COCKTAILS

LUNCHEON — DINNER

jor Credit — Private

ds Honored — Party Rooms

E. FAYETTE ST. — BALTIMORE, MD.

½ Block from Charles Center

539-1268

4

Broadview Restaurant

Cocktails • Dinners • Luncheons

Private Entertaining Facilities

116 W. University Parkway at 39th St.

CALL CH 3-1216

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD

Cocktails — Mexican Beers

Tuesday thru Sunday

Open 5:00 P.M.---12:00 P.M.

Dinner and Snacks

Closed Monday

Phone 435-9858

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

• *Cocktail Lounge*

• *Luncheon*

• *Dinner*



Your Host

Tom d'Anna

539-9021

12

Dobbs House

Breakfast-Luncheon-Dinner

Banquets-Meeting-Private Parties

We Cater Wedding Receptions

Located in Quality Court Motel—West

U.S. Route 40 & Beltway Exit 15

5801 Baltimore National Pike

744-1510

7

Miller Bros.

"The Place to Eat"

NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call 752-4822

Westview Lounge & Supper Club

CING NIGHTLY • LUNCHES & DINNERS

Finest Sea Foods

Prime Meats

5653 Old Frederick Road

of Ingleside Ave., off Baltimore National Pike

KUCHTA,

nager

Phone 744-0223

6

MILTON INN

Circa 1740

Dine Amid Early American Charm

Warm, Gracious and Inviting

Selected By Life & Time Magazines

as One of America's Finest Inns

Lounge & Dining Room Available

for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.

SPARKS 771-4366

10

Club Venus

SPECIAL AT THE

FABULOUS CLUB VENUS

An Evening for Two . . Only **$15**

Offer good every night except Saturday

Make Reservations Now

Perring Plaza Shopping Center—Beltway Exit 30

For Reservations Call NO 8-2232

Colorado Reports 120 Abortions

During the first eight months of Colorado's new abortion law, 120 legal abortions have been performed according to a report from the Colorado State Health Department.

Nine of these abortions were performed on rape victims, two were suicide risks, 50 underwent the operation for psychiatric reasons, 22 were granted abortions because their pregnancies presented a physical danger to the mother or child, and 37 cases were for other reasons.

According to the report, 29 of the women on whom abortions were performed resided outside the state of Colorado.

Before the law was liberalized less than 40 therapeutic abortions were reported annually in Colorado.

save time! save trouble! save money!

Forms & Stationery For Medical Offices

Our Professional Service Division makes a specialty of stocking many forms for the profession.
It's so easy and economical to have all your stationery requirements taken care of by folks who understand your need for quality, accuracy and service.
We'll be happy to be your "Stationery Room," delivering your printing as you use it, promptly.
Let's get together – today!

EAGLE PRINTING COMPANY, INC.
1021 Cathedral Street
2 Minutes Away—at 752-5400

Brentwood Inn

FRENCH CONTINENTAL CUISINE

Smorgasbord Luncheon and Dinner every Tuesday . . . . .

"Home of Maryland's Internationally Famous Wine Cellar" . . . .

We honor all preferred Credit Cards

● *NEW!* Another Dining Room has been added to accommodate our many guests ●

OPEN DAILY & SUNDAY 11 A.M. to 2 A.M.

Fifth Ave. & Brentwood—1 block N. E. of Dundalk and Holabird Ave. 1 mile from Holabird Ave. Exit of Baltimore Harbor Tunnel

We cater to Private Parties, Banquets and Dinners

AT. 5-0520 *Ample Free Parking* BALTIMORE, MD. 21222

ABBEY RENTS
SICKROOM EQUIPMENT

Prompt, professional service 24 hours a day, every day! A complete line of hospital beds, wheelchairs, traction equipment, oxygen, crutches, walkers, commodes, lamps, whirlpools—everything to help patients get well faster.

We Process MEDICARE Equipment Claims.

358-3400
6316 Reisterstown Road
Baltimore



heavenly relief
for unearthly cough

Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

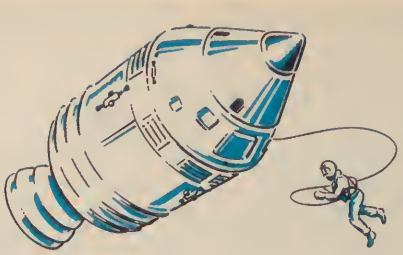
ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



"The inconvenience of a cold"

or a cold, NTZ® Nasal Spray provides rapid relief of asal symptoms. Relief starts with the first spray which pens the inferior part of the common meatus. A second pray, a few minutes later, will shrink the turbinates to elp provide sinus drainage and ventilation. Dosage ay be repeated every three or four hours as needed, r temporary relief of symptoms. NTZ is well tolerated ut overdosage should be avoided.

s a sinusitis deterrent, NTZ Nasal Spray can be used to eep the nasal passages open during a cold to help pre- nt development of acute sinusitis—or to help prevent e acute condition from becoming chronic.

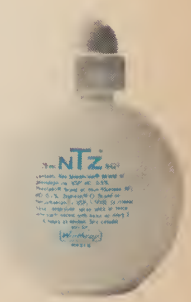
upplied: NTZ Nasal Spray, plastic squeeze bottles of ml.; NTZ Nasal Solution, bottles of 30 ml. (1 fl. oz.) th dropper.

NTZ is more than a simple vasoconstrictor. It contains

Neo-Synephrine® (brand of phenylephrine) HCl 0.5 per cent, the major component, virtually synonymous with fast, efficient but gentle nasal vasoconstriction.

Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, topical antihistamine for reduction of rhinorrhea, sneezing or itching. It combats the allergic reactions that may occur in colds or sinusitis.

Zephiran® (brand of benzalkonium, as chloride, refined) 1:5000, antiseptic preservative and wetting agent to promote penetration and spread of the formula.



Winthrop Laboratories, New York, N.Y. 10016 Winthrop



THE BETTMAN ARCHIVE

Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

ANTISECRETORY SEDATIVE

Antrocol

Antrocol provides the prompt, predictable antisecretory action of the belladonna alkaloid, atropine, fortified with sedation and blended with Bensulfoid, contributing to slow, even absorption.

Each Antrocol tablet or capsule contains 0.324 mg. of atropine sulfate, which is twenty-four thousandths of a milligram more than the smallest effective dose specified in U.S.P., Vol. 17. This slight increase in the smallest effective dose of the antisecretory factor (atropine) is all the average patient can tolerate without discomfort.

One Antrocol tablet or capsule taken three times daily lessens emotional stress and maintains a gastric function that is not conducive to the development of peptic ulcer.

Antrocol is also useful in the treatment of peptic ulcer. Dosage up to 8 tablets or capsules per day to obtain the desired antisecretory titer. When ulcer has healed, one Antrocol tablet or capsule morning and evening gives protection against recurrence.

Each tablet or capsule contains:

Atropine Sulfate	0.324 mg.
Phenobarbital (may be habit forming)	16 mg.
Bensulfoid, see white section P.D.R.	65 mg.

Side-effects: Toxic levels of atropine may produce flushing, dry mouth, blurred vision, tachycardia, or urinary retention. Precautions: Do not use in glaucoma. Use cautiously in prostatic hypertrophy.

Federal law prohibits dispensing without prescription.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Antrocol®
ANTISECRETORY SEDATIVE

John Ruxton
Trust Department
Equitable Trust Bank
Baltimore, Maryland 21203

Please send me more information on HR-10

Name_____

Address_____

City_____ State_____ Zip_____

This coupon can cut your taxes, provide for your retirement, and put more money in your pocket.

The Keogh Act, HR-10, is finally law. And it enables you to set up a retirement plan, cut your taxes, and have more money in your pocket. But it won't do a thing for you unless you act on it. So do it now. Risk a 6¢ stamp. We'll send you a booklet telling you simply, clearly, what the advantages are to you.

Equitable
Trust Bank
Baltimore, Maryland 21203
Member Federal Deposit Insurance Corporation

HOUSE IN THE PINES
NURSING HOMES

☐ Thoroughly modern facilities

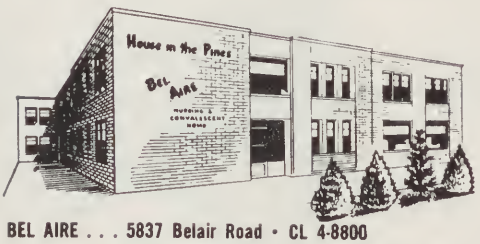
☐ Professional care 24 hours a day

☐ Pleasant, home-like atmosphere

☐ Complete Occupational, Recreational and Physical Therapy programs supervised by our staff therapist

☐ Modern kitchen serves well-balanced, tasty meals planned and supervised by our licensed staff dietician

☐ Physicians' instructions followed explicitly



BEL AIRE . . . 5837 Belair Road • CL 4-8800



CATONSVILLE . . . 16 Fusting Avenue • RI 7-1800

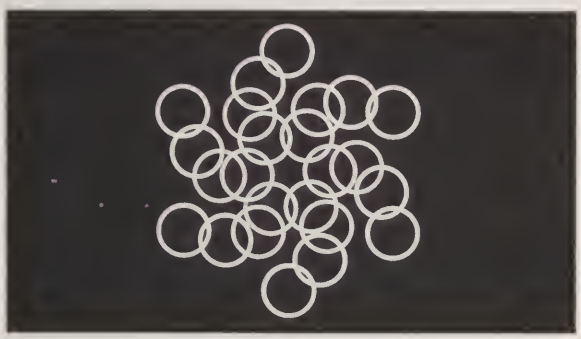


BELVEDERE . . . 2525 W. Belvedere Ave. • FO 7-9100



EASTON, Md. . . . Rt. 50 & Dutchman's Lane • TA 2-4000

Your inspection invited
free brochure on request
participating in the
Medicare program



From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Management of Acute Phases of Alcoholism, Including Delirium Tremens

Clinical experiences on 412 patients hospitalized for acute alcoholism during the period of July 1967-July 1968 were presented by representatives from Provident Hospital, Church Home and Hospital, Spring Grove State Hospital, and Baltimore City Hospitals during a conference on October 9, 1968 at Baltimore City Hospitals.

The conference was set up to review the experiences with the hope of generating interest in general hospital treatment of patients suffering from acute alcoholism and in trying to improve the management of such patients. Conference moderator and reporter was E. G. Beacham, MD, Chief, Tuberculosis Division, Baltimore City Hospitals.

Esteban Mezey, MD, Assistant Chief Hospital Physician, Metabolic Unit, Alcoholism Grant Program, Baltimore City Hospitals, reviewed the physiological and biochemical aspects of acute withdrawal from alcohol.

Dr. Mezey stated that the withdrawal symptom complex principally consists of a state of increased nervous excitability manifested by increased motor, perceptual and autonomic activity. Magnesium deficiency may be responsible for some of these symptoms, but it is not the major cause—especially in the case of delirium tremens.

The appearance and intensity of withdrawal symptoms correlate with the amount of alcohol consumed and the length of the period of intoxication. The depressant action of alcohol causes a reduction in central nervous system activity which will register on an electroencephalograph. If cessation of alcohol intake is abrupt, hyperactivity is registered by the appearance of transient spikes and sharp waves of rhythmic paroxysmal discharges.

Due to the inhibition of anti-diuretic hormone production following acute alcoholism, diuresis is often seen. With chronic alcoholism there is a marked water and electrolyte retention. The clinical state in this case may depend on factors caused by the alcoholism and the condition of the liver.

Alcohol, in *in vitro* preparations of brain and other tissues, inhibits the active transport of sodium and potassium across membranes. Such effects could possibly explain the changes in fluid and electrolyte balance and depression of the central nervous system, as well as the hyperexcitability noted in the withdrawal syndrome.

Roland Smoot, MD, Chief of Medicine, Provident Hospital, reported on 124 patients (100 male, 24 female) who were seen on a voluntary basis in the hospital's Detoxification Unit between January and July, 1968.

Most of the patients had imbibed alcohol up to one or two hours before admission. Immediately upon admission, most of the patients were given chlordiazepoxide (Librium), 100 mg intramuscularly, then placed on 25 mg orally, four times daily. Additional intramuscular doses were given as necessary. Intravenous fluids were seldom

used since juices and other oral fluids were available at the bedside. Supplemental vitamins and antacids were given, and chloral hydrate was given at bedtime, but paraldehyde and barbiturates were not included in the treatment. Convulsive disorders were controlled with amobarbital (Amytal) or diphenylhydantoin (Dilantin).

Visitors were limited to family and AA members.

According to Dr. Smoot, the patients generally slept well the first night, improved rapidly, and were discharged in five to six days. The patients developed a minimum of complications, and none of them developed DTs. He felt that acute alcoholism could be treated in a general hospital without disturbing the equilibrium of the institution.

Albert Nahum, MD, Director of Medical Education, Church Home and Hospital, presented his study of 32 admissions (19 male, 13 female) spanning the period of July, 1967 to January, 1968.

Since 1963, Church Home has had a cooperative hospital treatment program with the Alcoholism Clinic of the Baltimore City Health Department. Patients are generally admitted through the clinic program or by private physicians.

Upon admission, the patients were given a complete physical examination and laboratory work up, plus chest and skull X-rays and liver-function tests. A complete history was also taken. Some of the patients received 100 mg of chlordiazepoxide every four hours, and 50 mg of promazine (Sparine) every four hours for 24 hours intramuscularly. On the second to fourth day an overall evaluation was made and long-range plans were established. For other patients, a regimen of disulfiram (Antabuse) was prescribed; chloral hydrate was given at night. Paraldehyde was not used.

The patients stayed an average of five to ten days. There were few complications, possibly because no patients were admitted with delirium tremens or in a comatose condition.

Spring Grove State Hospital's representative reported on 214 patients with acute alcoholism seen January 1 through June 30, 1968. **Ferdinand Massari, MD,** Director of Alcoholism Rehabilitation Unit, stated that during this period there was a total of 2,130 mental hospital admissions of which 806 (38%) were diagnosed as alcoholics. Most of the patients in the latter category were treated in general medical wards. Less than one-third of the patients suffering from acute alcoholism were treated in the alcoholism unit.

Treatment in the unit consisted mostly of paraldehyde, although chlordiazepoxide, thioridazine hydrochloride (Mellaril), hydroxyzine pamoate (Vistaril) and other drugs were used. Depending on the size and condition of the patient, 8-10 ml of paraldehyde every four to six hours was administered. Occasionally, 100 mg of chlordiazepoxide was given every four hours intramuscularly before the patients were switched to paraldehyde. Vitamins were dispensed; milk and orange juice were freely available on the ward. No fluids were given intravenously.

The average age of the patients was 45. Most of them stayed four days on the unit then were sent to a dormitory for chronic care. Only four of the 214 developed seizures while on paraldehyde and two of these patients had a history of seizures. Liver-function studies showed 86 patients had SGOT/PT over 200 levels, all except three returned to normal in two weeks. Three cases of active tuberculosis were found.

Dr. Massari concluded that most of his patients had been drinking for years, yet had maintained family and social ties. He felt that because many of the patients complained of anxiety, which was not relieved by sedation, drugs should be discontinued as soon as possible.

Alcoholism patients are treated in general medical wards at Baltimore City Hospitals. **Bruce Bucher, MD,** Medical Assistant Resident, reported on 42 patients (36 male, 6 female) seen January 1 through July 30, 1968. The average age of the patients was 44. Thirteen of the patients were admitted with delirium tremens, one with DTs and comatose, two suffering from hallucinations and alcoholic coma, and two were diagnosed with tremulousness. Twenty-nine of the 42 admitted to drinking alcohol within 12 hours prior to admission.

Because of the variation in tests and range of results, no general comments could be made about the laboratory findings. Hematocrits averaged 38 mm; WBC averaged 9,300 (4,200-18,500); platelets 17/42 averaged 154,000 (normal range: 200,-000-400,000); two patients had hypoglycemia on admission; many had elevated SGOT/PT.

Treatment was varied although paraldehyde was the only sedative mentioned for 28 patients. Chlordiazepoxide and paraldehyde were given to two patients and chlordiazepoxide, alone, to four patients. Fourteen required intravenous fluids. There were seven deaths (16%)—two related to

pneumonia and septicemia; one to subarachnoid hemorrhage; one to ruptured abdominal aneurysm; and one to tuberculosis. Hospital days averaged 12 (actually eight if five patients are excluded because of long-term treatment for concurrent diseases).

Louis Faillace, MD, Chief of Psychiatry, Baltimore City Hospitals, criticized the lack of definition in the above presentations and stressed the difficulty in comparing widely varying programs.

He cited a study at Boston City Hospitals in 1952 where in 266 consecutive alcoholism admissions, acute inebriation was diagnosed in 21%; alcoholism and tremulousness in 34%; hallucination and tremulousness in 11%; acute alcoholism and hallucination in 2%, and delirium tremens in 5%.

Dr. Faillace suggested that all drug regimens seemed to work for the people using them.

In a brief preliminary report on a psychological study at Baltimore City Hospitals, it was suggested that patients with acute alcoholism, as compared with chronic alcoholics and non-alcoholics with other acute or chronic conditions, had difficulty in recalling information given during the acute alcoholism phase and that this period of poor recall lasted about three weeks. This implies that instructions and discussions held during the acute phase would be of limited value, and that a more appropriate time for such discussion would be after this three-week period.

John Hirschfeld, MD, President of the Baltimore Area Council on Alcoholism, commented on 30 private patients—40% female—who have been treated in general hospitals since 1962. In most cases he administered chlordiazepoxide and promazine and frequently noted underlying medical conditions and a special problem regarding burns of groggy cigarette smokers.

Harry Klinefelter, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine, added that he thought that patients suffering from acute alcoholism could rarely be treated at home. He stated he dislikes paraldehyde because of its odor, possible addictive properties, and because it could depress respiration.

Continuing on the subject of drugs, **Conrad Acton, MD,** related his experience with 11,000 cases of acute alcoholism treated in the Baltimore City Jail over a three-year period (1963-66). Only seven deaths occurred (excluding hospitalized patients). He used thioridazine hydrochloride and fluids orally as basic treatment.

Julius Krevans, MD, Chief of Medicine, Baltimore City Hospitals, stressed the need for superb medical care facilities for the treatment of acute alcoholism. He mentioned the vast differences in patient types and problems in different hospitals; the dangers of all drug regimens, specifically in cases of hypotension if phenothiazine derivatives are used; and the incidence of depressed respiration with most sedatives. He urged careful plans for, and objective evaluation of treatment programs.

Maxwell N. Weisman, MD, Director of Alcoholism Programs for the State Department of Mental Hygiene, seconded this point of view and asked that attempts be made to establish a rationale and criterion for medical regimens.

The conference was successful in emphasizing and confirming the urgent need for uniform, statewide general hospital programs for the treatment of acute alcoholism. Uniformity must be established in the definition of terms, acute treatment plans, evaluation of patients and treatment regimens, and follow-up programs.

It was demonstrated that the establishment of such a program did not and would not hinder the administration of a hospital.

STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

We Repair and make Lamps
"Lamps make the home Beautiful"

LE 9-0222 403 N. Charles Street
Baltimore, Md. 21201

Help for the Alcoholic:
HIDDEN BROOK
Understanding care in an atmosphere conducive to Recovery



Request Brochure. Call 734-7554
Thomas Run Rd. Belair, Md. 21014

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

FLORISTS TELEGRAPH DELIVERY
F.T.D.

Geo. **RADEBAUGH**
& Sons

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300

(Continued from page 32)

with South High athletes, moments after his son, Mac, was awarded the Principal's Trophy at the 12th Annual All-Sports Banquet. The problem of available backup beds in the county was approached by a resolution to open the 50 unused beds at Western Maryland State Hospital.

In April, John C. Stauffer, MD, took off again, this time to Pakistan with N.A.I.D. for one and one-half years. His family accompanied him. His latest address is J. C. Stauffer, MD, PMRC; 6 Birdwood Road; Lahore, Pakistan (25¢ airmail postage—no enclosures).

Ladies Night in May at the Airport Inn was filled with suspense, awaiting the flight of the Hon. Charles M. Mathias, Jr. Due to a storm, he "flew" in by car. The meeting was the largest ever and the crowd heard "Mac" speak of some of the national problems as seen thru the eyes of the legislator. Sheriff Charles E. Price was given the Layman of the Year award for outstanding community service. Also Ralph S. Stauffer, MD, was presented a 50-year pin, he was speechless.

"Weekend with Doctors", sponsored by the Heart Association of Maryland, took three Washington countians to Frostburg State Teachers College in June. Dr. Kehne was keynote speaker with Dr. Gist, speaking on obstetrics and R. A. Young, MD, pediatrics. In Cumberland, Western Maryland Heart Association awarded a medallion and certificate of merit to Dr. Young, the first president of the amalgamated group. John H. Hornbaker, MD, was singled out for his work on the medical advisory committee, and for receiving sanction to establish a cardiac diagnostic center, both in Hagerstown and Cumberland. This county is represented by Howard N. Weeks, MD, Dr. Young, R. T. Binford, MD, and Dr. Hornbaker on the board. Also in June, awards were given to two graduates from the nursing school. The scholarship program has placed the first recipient in medical school and has four high school graduates under stipend.

In September the co-sponsored Lederle Sym-

posium on the "Problems of Sexuality Encountered in Clinical Practice" was an outstanding event featuring Joseph B. Trainer, MD, University of Oregon Medical School; Paul J. Fink, MD, Hahnemann Medical College; and Beverley T. Mead, MD, University School of Medicine, Omaha. This program set forth future expansion of the sex education program in Washington County Schools with the cooperation of the medical society. On September 29, 1968, the new wing of the Washington County Hospital was dedicated. This was the major part of a $5.5 million expansion program and includes the emergency room, operating room, intensive care unit, and EEG lab. It increases beds to 475 and makes the hospital the largest in Maryland outside of Baltimore.

Our theme at the local Health Fair was a pointed exhibit of the seat belt problem, using photographs of local accidents and the AMA exhibit. We have received thanks from accident victims whose lives were saved by seat belts, used only after seeing this exhibit.

Harry D. Bowman, MD, and Ralph F. Young, MD, were granted Emeritus status. J. Walter Layman, MD, has requested same and has been so recommended to the House of Delegates.

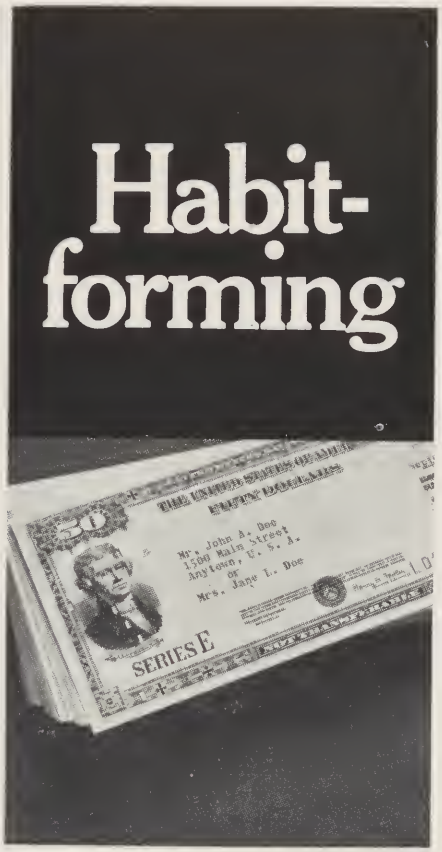
Worcester County Medical Society

The Worcester County Medical Society elected new officers recently, naming Francis J. Townsend, MD, of Ocean City to serve as president in 1969.

Other officers are: F. S. Waesche, MD, of Snow Hill, vice-president; and Norman Sartorius, Jr., MD, of Pocomoke, secretary-treasurer.

Delegates are Dr. Townsend and Robert C. Lamar, MD, of Snow Hill. Named to be Censors were Charles Trader, MD, of Pocomoke, 1969; Dr. Lamar, 1970; and Lloyd O. Long, MD, of Snow Hill, 1971.

The society also voted Dr. Long in as an official member.



When you stack one U.S. Savings Bond on top of another, it becomes a habit that's tough to break and hard to beat. That's because it's so painless. Just tell your employer or banker to set aside a regular amount for you before you have a chance to spend it. Sign up today.

New Freedom Shares

Bonus opportunity for people who buy Bonds through the Payroll Savings Plan or Bond-a-Month Plan — a new U.S. Savings Note called Freedom Shares. It pays a higher rate of interest and matures faster. Get all the facts where you work or bank.

U.S. Savings Bonds, new Freedom Shares

BENEFITS OF CONSULTATION

Consultation benefits both the patient and the physician. An additional opinion gives assurance to the patient and his family; it supports your own judgment; it provides positive evidence of good medical practice if you are sued.

Consultation is advisable:

1 — If the patient wishes it.

2 — In difficult cases, especially fractures, where there are two or more acceptable methods of treatment.

3 — Whenever the patient doesn't progress as he should.

4 — If you feel there are aspects of a case that are beyond your experience.

5 — When you feel that the patient is "suit-prone."

The prompt identification and treatment of complications and bad results are all-important in preventing malpractice suits. If a suit does result, it is most helpful to be able to show that another physician was consulted.

This is the new 144S Volvo Sedan For 1969



What a prescription for "Same-old-car-itis."

Volvo offers the most advanced safety features of any car. It's so economical it gets up to 25 m.p.g. With automatic transmission, stereo tape, air conditioning available—and world famous Volvo quality built-in, we think you'll agree the prognosis is extremely favorable.

FREE 24 HOUR DEMONSTRATION

michaelson motors, inc.

America's Largest Volvo Dealer
5801 REISTERSTOWN RD.
Open Nitely 'til 9:30 • 358-5800

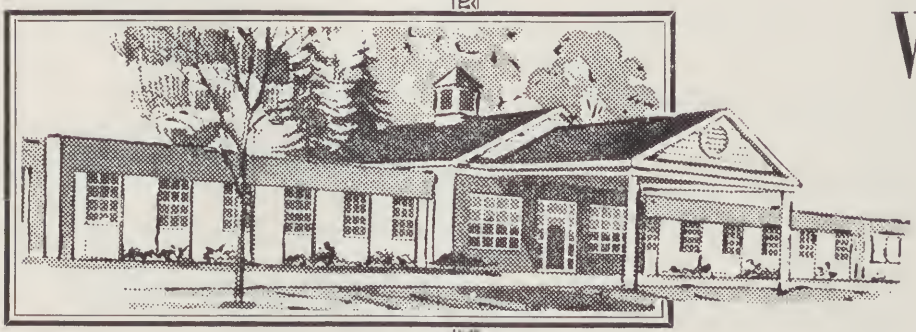
★ This extended care Nursing Home is Approved by the Joint Commission on Accreditation of Hospitals
★ One story new fire-safe construction.
★ No steps, ramps or elevators needed.
★ Inspection invited. Reasonable rates.
★ All facilities available to private physicians.

Where your convalescent Elderly, Bedfast or Disabled

Enjoy being special

V. I. P.'s

(VERY IMPORTANT PARENTS)



★ Professional Total Care Program
★ Continuous Physical Rehabilitation by registered therapists in specially equipped department.

PHONE VALLEY 8-6500

Dulaney Towson

NURSING & CONVALESCENT HOME
111 West Road, Towson

Off York Rd. Beltway Exit 26 South

Dysfunctions of the Keogh
or
What to do until help arrives

This article is designed to provide guideline information in regard to the subject matter covered. It is not intended to provide, nor should it be construed, as offering legal advice or counsel. For such advice or counsel, we refer you to your attorney. In addition, this article is intended to comply fully with the rules, regulations, and ethics of the National Association of Bankers, Life Underwriters, Security Dealers and, of course, to all local, State and Federal laws and regulations.

The abnormal pathology of Keogh meets with a set of signs and symptoms, which, to the uninitiated, present an ominous picture of morbid possibilities, analogous to the subjective response of the sophomore medical student upon first exposure to morbid pathology.

Be of good cheer: All that looks ominous is not necessarily the reality of danger. In actual fact, dysfunctions of the Keogh occur quite infrequently; the misplaced apprehension stimulated by the unfamiliar is quite out of proportion to the actual danger. But the pathology makes for an interesting literature.

While Keogh was conceived in 1951 (the embryo then being known as the Jenkins-Keogh syndrome), the infant did not emerge from the womb of its mother, the Internal Revenue Code, until 1962. Not atypical of such offspring, the child is verbose, unnecessarily complex, ambiguous, ultrasensitive to the slightest stimulus, and above all, deceptively simple in appearance.

It is regrettable that much of the current Keogh literature unintentionally supports the mistaken concept of Keogh as a simple piece of legislation. Actually, nothing could be further from the truth: A biopsy of the law, together with extensive practice in this field, directly contradicts such a notion. Evidence of dysfunctions of the Keogh has become increasingly available. Examples of the more common types are offered herewith:

I. You didn't contribute as much as you could have . . . (or as much as you were supposed *to contribute by the terms of your plan). You agreed to contribute* 10% *of your income and you only contributed 7% of your income.*

If you didn't have a secretary included in your plan, I wouldn't worry about it. I think the Internal Revenue Service will forgive you. Technically, you may have violated the terms of your plan, but since *you're* the only loser, I repeat: I wouldn't worry about it. You lost your tax-saving deduction on the additional 3%, of course, but you're the only loser, so forget it.

I presume that you want to know whether you can put in *13% next* year—that is, your regular 10% plus the 3% which you first overlooked.

I'm sorry: 10% is your limit in any year.

Now, on the other hand, if you have a secretary included—that's a slightly different story.

Once again, you may have technically violated the requirements of your plan, but at a slightly more serious level. After all, 10% was your commitment to her, and she has the right to expect you to live up to it. Under the terms of many, if not most, Keogh plans, you could put in the additional 3% for her right now—this year. I'd do it, if I were you; and I'd even add some interest—at a reasonable rate—say, 4%, figuring from the end of last year. You can deduct this 3% contribution for her this year (1969), and later on, when you contribute your 10% for *this* year, you'll contribute the 10% for *her,* too. That'll give her *13%* for the year, while you only get the benefit of *10%*. Yes, it does seem possibly a bit unfair, but—the law, you know. . . .

II. Your secretary became eligible during the year and you completely forgot to contribute for her.

That's a most unfortunate oversight. I'm afraid Internal Revenue may disallow your deduction for this year. One has to be careful about these things.

III. You made a contribution of $2,500 but discovered later that you had over-*contributed; you were entitled only to a deductible contribution of $2,100.*

Yes, this sort of thing happens from time to time. Well, what the results of this "excess-contribution" (legal parlance) may be will depend on several factors, and the first of these is whether or not you have an employee who is in Keogh with you.

If you have *not,* Internal Revenue will probably notify you in due time that you have made an "excess-contribution" and will suggest that if you don't remove it forthwith, you will suffer several penalties. Of course, you don't have to wait for the notice. (*I* wouldn't—I'd take action right away), but in any event, you'll have to get back your "excess-contribution", correct your income-tax return and pay Uncle Sam what you owe him.

Now, on the other hand, if you have an employee *in the plan,* with her participation came an additional privilege: that of contributing an *additional* 10% (or $2,500) on a *non-deductible* basis. (You may wonder why on earth you should even consider contributing an additional amount which is *not* tax-deductible. There's an excellent reason: You will pay no income taxes on any of the dividends or capital-gains which this additional contribution makes for you. In other words, the *earnings* are tax-free. And that can be a *mighty important* reason!)

Incidentally, in order to do this, the *particular* Keogh plan which *you* adopted—there are dozens of different Keogh Plans—must *give* you this privilege . . . of making these additional contributions; and—extremely important—should allow you yet another privilege: the right to take this money *out* whenever you wish. The law permits both, but many Keogh plans, unfortunately, are not as liberal as the law.)

If, however—as I said before—you *do* have an employee in the plan with you, and *if* your Keogh plan permits you to make these *additional* non-deductible contributions, and *if* you either, a)—didn't take advantage of this privilege, or b)—didn't contribute as much *additionally* as you were permitted, then: this "excess contribution" can be "poured-over", so to speak, from the *deductible* part to the *non*-deductible part, in which case you will *not* have to take it back, you'll simply have to correct your income-tax return, showing your *deductible* contribution as $2,100 (the limit you said you were permitted to make), also showing a *non*-deductible contribution of $400. (Incidentally, if, as and when you make these *non*-deductible contributions, you *really* should keep a separate record of them . . . just the proper notations on your check stubs will help. It's *most* important from a tax-point-of-view that you know exactly, on the one hand, how much you contributed as a *deductible* item, *and what that money was invested in,* and, on the other hand, how much was contributed on a *non*-deductible basis, and what *that* money was invested in.)

Of course, if you had already made a *non-deductible contribution* of as much as you were permitted to contribute, then we're back to the "excess-contribution" again with which we started this section of this article; you'll have to get back your "excess-contribution", correct your income-tax return and pay Uncle Sam what you owe him.

IV. You made the same contributions this year as you made last year, forgetting completely that there had been salary-changes.

(I think that a re-reading of Sections I and III of this article will throw some light on the probable sequelae.)

V. You made the contribution too late to reach the Trustee or Insurance Company on time.

Yes, we see a "fairish" amount of this. I suggest that if you mail your contributions during the last 5 days of the year, you mail them by either Certified or Registered Mail—and keep the receipt. You should have no further problem with this. But if you have no such proof of timely mailing, I'm afraid you're out of luck—you'll lose your deduction for the year. (There simply *must* be a line drawn *somewhere,* mustn't there—.)

VI. You bought an apartment house (or some other kind of un-*incorporated business), and with it you acquired another employee who was eligible for inclusion in the plan, and you didn't know that the law required this, and so you didn't contribute for him.*

Yes; an unfortunately dangerous trap for the unwary, particularly because it's *so* easy to overlook. I'm afraid you're going to lose your tax-deduction for the year. *Do* try to keep this sort of thing in mind.

VII. You took in a partner or partners; or added a partner, or partners; or changed a partner, or partners.

Don't make me go into this—this way lies madness. My best advice: Make the patient comfortable, apply artificial respiration and call for professional assistance immediately.

VIII. You're over 70½ years old, so you didn't go in because you knew (!) that this wasn't allowed after age 70½.

Poppycock! Of *course* you can go in . . . and get your deduction, too! (Government Retirement Bonds might be your best bet at this age.)

IX. You're less than 59½ years old, you bought U.S. Retirement Bonds and now you find out that you're not eligible for tax-savings because you're not really "self-employed". (The things that happen in this world!)

Write the Bureau of the Public Debt, c/o the Fiscal Service of the Treasury Dept., and tell 'em your sad story; you may be able to get your money back.

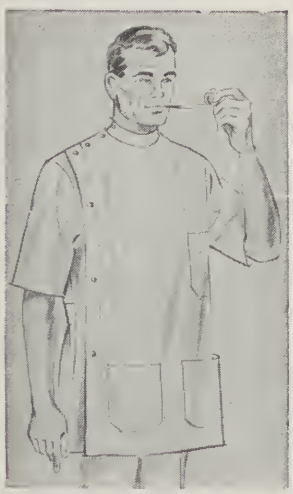
As you may have noticed, the literature concerning these dysfunctions is, unfortunately, well-nigh non-existent. We submit this contribution in the general interest.

We cannot help but conclude, however, that post-sale attention seems deplorably lacking. We urge that the necesity for *competent* and *continuous* attention not be overlooked.

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#800—100% Nylon Taffeta **$5.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only
Sizes 34 to 46



- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46

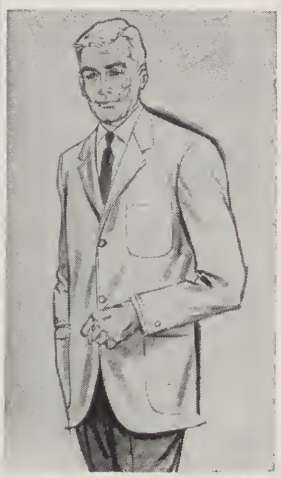
Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**



MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

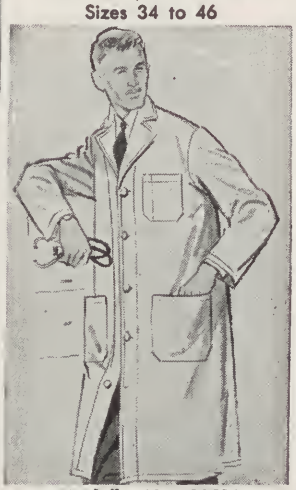
Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab. **$9.99**

Sizes 28-40



OTHER STORES IN →

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545



CCTV TOTAL SYSTEMS

PLANNING, ENGINEERING, INSTALLATION & SERVICE

We Feature **AMPEX**

VIDEOTAPE RECORDING EQUIPMENT

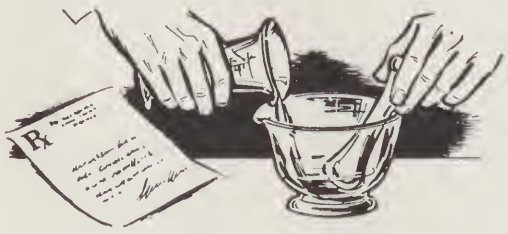
Call Today for a Free Demonstration

high fidelity house

6307 YORK ROAD BALTIMORE, MD.

(Drumcastle)

Phone 323-3713



Your old friend

BELLADONNA

ALKALOIDS & PHENOBARBITAL

HYOSCYAMINE 0.30 mg. ATROPINE 0.06 mg.
HYOSCINE 0.02 mg. PHENOBARBITAL ¾ gr.

Now available in a long-acting capsule . . . . . .

For Sample and Literature
ANN-LEE LABORATORIES, INC.
P. O. Box 377
Randallstown, Md. 21133

Name .....

Address .....

.....

City State Zip

PHEN-BEL

CAPSULES

Your patient no longer has to worry about leaving his bottle of "pills" at home while at work. One PHEN-BEL Capsule in the morning and another at night for "round the clock" action.

The Cost is Reasonable

ANN-LEE LABORATORIES, INC. *Distributors*

RANDALLSTOWN, MD. 21133



A Service of the Tuberculosis Association of Maryland

tuberculosis

Exposure to Cold Environment and Rhinovirus Common Cold

Volunteers without antibody to a rhinovirus strain were subjected to a cold environment before and after inoculation with the viral strain. No effect on the illness was demonstrated, despite popular belief that cold has an adverse effect on the common cold.

Although in animals exposure to cold has been shown to increase both the frequency and severity of viral infections, such exposure has not been demonstrated to increase the susceptibility of man to infection with common-cold viruses. Studies published to date, however, have been performed with volunteers whose antibody status to the infecting virus was not known.

For the present study, 44 volunteers found to be free of antibody to rhinovirus type 15 were inoculated with purified stocks of this strain. Of these, 27 were exposed to cold at the time of inoculation and during incubation, illness, and recovery. The remaining 17, who served as the control group, were not exposed to cold.

To test the normal reaction to the cold devices used in the study, five additional volunteers, wearing light cotton shorts and undershirts, spent one and one-half hours in rooms with temperatures of 4° and 10°C (centigrade). Since the cold caused shivering which led to elevation of body temperature, adjustments were made to lower body temperature. These consisted of immersion in a water bath at 32°C for four to six hours and of wearing wool jackets in the 10°C room.

The subjective opinion of the volunteers was that the experience in the 4°C room was uncomfortable and comparable to the short-term chilling commonly encountered in nature. In contrast, when placed in a tank with 32°C water three days later, they found the experience comfortable.

Inoculation of the 44 subjects was done by small particle aerosol in 28, by nasal instillations of virus-containing fluids in 16. There was no difference in clinical response to the two methods.

Inoculated After Exposure

In one experiment, 9 of the 16 volunteers inoculated by nasal drops were infected at the end of exposure in the 4°C room. The other seven were not exposed to cold. Infection rates in both groups were similar and the illnesses were typical of the common cold. All the infected persons demonstarted early-high virus-shedding patterns. In each an eight-fold or greater rise in serum neutralizing antibody developed five weeks after inoculation. Titers in both groups were comparable.

In following experiments, six volunteers were placed in the 10°C room and seven in the cold bath on the morning after inoculation. Both exposed groups were compared to unexposed volunteers inoculated at the same time. Results were similar in all three groups. The frequency and severity of illness were not significantly greater in the group exposed to cold than in the unexposed volunteers. Furthermore, there was no increase in quantities of virus shed from the nasopharynx among volunteers exposed to cold. Antibody responses among those exposed were also similar to those not so exposed.

Clinical responses, virus-shedding patterns, and

antibody responses were also similar in two volunteers placed in the water bath on the first or second day of illness and two others inoculated at the same time but not exposed to cold.

Illnesses Similar

In another experiment, six volunteers were placed in the 10°C room and seven in the water bath on the seventh or eighth day after inoculation. Illnesses in the two groups were similar.

When four volunteers were re-exposed to cold in the water bath, nasal obstruction and discharge developed in three. In two, the symptoms disappeared within eight hours; in the third, who also had headache and cough, the symptoms lasted for 24 hours. No symptoms were observed in the three volunteers first exposed to cold after recovery from illness. Virus-shedding patterns and mean antibody responses were similar in both groups.

Pneumococci and staphylococci as well as nonpathogenic species of bacteria were recovered from nose and throat swabs from both the volunteers exposed to cold and from those not exposed in each of the experiments.

No effect of exposure to cold on a common cold due to rhinovirus type 15 that might account for the popular belief that cold was bad for a common cold was demonstrated. However, two possible mild effects of cold on rhinovirus illness were noted. One was a slight increase in nasal symptoms in three of seven volunteers exposed to cold during recovery, and the other was a slightly greater frequency of illness among some subjects exposed to cold during the incubation period. In both, the difference between subjects exposed to cold and the non-infected subjects in the control group was minimal.

Failure to demonstrate a relationship between cold and the common cold could be because environmental temperature has no effect on the common cold; or because exposure for longer periods or to more severe conditions may be necessary to influence the course of common colds. It may be, too, that exposure to cold influences the course of other viral illnesses in man, but not rhinovirus illness.

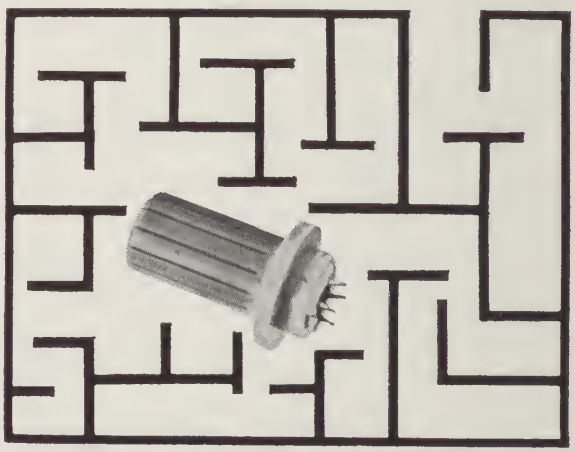
It is also possible that infection with a wild rhinovirus and its tissue culture progeny would have a different result, as might exposure to a different strain of virus. However, rhinoviruses are the most frequent isolates from adults with colds and, with the possible exception of type 1A, there are no predominant serotypes.

No Bacterial Complications

Exposure methods used in the study permitted testing of differing effects of cold. The 4°C room was analogous to short-term chilling of the type encountered in nature. The water bath was a comfortable procedure, but produced a fall in body temperature.

None of the volunteers had bacterial complications such as otitis media or pneumonia. The presence of potentially pathogenic organisms was not greater in the volunteers after infection and exposure to cold than in those after infection alone. In neither group were potential pathogens more frequent after infection than before inoculation. There was no evidence that respiratory viral infections predispose to pneumonia by qualitative changes in bacterial flora. More detailed bacteriologic studies will be needed to determine if significant quantitative changes occur in this regard.

Reprinted from *The New England Journal of Medicine*, October 3, 1968.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Medical Librarianship Aids

In January we listed recent biographical and organizational directories received by the library, hoping to give both physicians and other associations, as well as paramedical personnel an idea of the scope and availability of this type of information. Now it seems appropriate to mention a few of the more recent works of a professional nature mainly, in the field of librarianship.

Medical Reference Works, 1679-1966, a selected bibliography: One of the outstanding bibliographic publications of the past few years. Edited by John B. Blake and Charles Roos, published by the Medical Library Association as MLA publication number 3, in 1967. This bibliography of more than 2,700 titles grew out of the need for a separate bibliography which could be revised as needed, independent of the *Handbook of Medical Library Practice.* Previously, the Handbook had included the bibliography, the first edition in 1943 having 1061 titles listed, the second, 1956 edition, having 1965 titles. The third edition is now in preparation and will carry the numbering and title of the original publication, but Medical Reference Works will start out anew.

The staff of the National Library of Medicine has worked long hours to perfect and complete this very helpful reference tool for the furtherance and improvement of library service to the medical profession.

The three main divisions of the contents are: General Medicine; History of Medicine; and Special subjects. General medicine is arranged by form, such as: indexes and abstracts, bibliographies, translations, periodicals, directories, and congresses. History and special subjects are arranged alphabetically. Entries are numbered 1-2703 and indexed accordingly.

Bibliographic information is good, with short annotations, but trade information such as price is omitted, as well as the explanation of the symbols indicating titles recommended for small libraries. An indispensable bibliography for any medical library.

Other titles of interest are:

Occupational Health Bookshelf: selected reference as recommended by the Industrial Medical Association (Reprinted from the Journal of Occupational Medicine, volume 10, number 8, August 1968). Arranged by subject.

Historical Review of Medical Libraries in Brooklyn by Helen Kovacs, Director, Downstate Medical Center, State University of New York, Brooklyn, New York.

An interesting short history of the various libraries involved in the culmination of the Downstate Medical Center and its satellites.

Outline for the organization of hospital libraries, by Beatrix A. Robinow, Biomedical Librarian, McMaster University, published by Canadian Medical Association, 1967. A very good elementary manual on organization of the hospital library. Bear in mind that information, such as prices, is given from the Canadian viewpoint and spelling follows the British rule.

Yale's Selective Book Retirement Program, prepared by Lee Ash, editor and research analyst. Archon, 1963.

A report of a 3-year project under a grant from the Council on Library Resources, Inc. Mr. Ash outlines this project with the objective of assisting other libraries in establishing a weeding, storage, and eventual book selection program. He included plans for actual physical storage and technical routines involved, as cataloging. Valuable to libraries planning similar programs.

* * *

Before annual meeting in April, send your special requests for subjects or titles to the library so they can be included in our exhibit.

NEW ACCESSIONS—BOOKS

(Arranged by author and title)

Abrahams, Harold J.
Extinct medical schools of nineteenths-century Philadelphia. Philadelphia, University of Pennsylvania Press, 1966.

Alderman, Alice J.
Prescribed and nonprescribed medicines: type and use of medicines. U. S. July 1964-June 1965. Washington, U. S. Dept. of Health, Education and Welfare, 1967.

American Heart Association Summer Workshop Denver, 1967.
Measurement of heart chamber volumes and dimensions, a summary of the proceedings of a summer workshop, sponsored by the Council on Basic Science of the American Heart Association July 24-27, Denver, Colorado. New York, American Heart Association, 1967.

American Medical Association.
Horizons unlimited. A handbook describing rewarding career opportunities in medicine and allied fields. Chicago, American Medical Association, 1966.

Bauer, Mary Lou
Characteristics of persons with diabetes. U. S. July 1964-June 1965. Washington, U. S. Public Health Service, 1967.

Blake, Florence Guinness
Essentials of pediatric nursing. 7th edition. Philadelphia, Lippincott, 1963.

Calderone, Mary C.
Sexual health and family planning. New York. American Public Health Association, 1968.

Godley, Frank H.
Fertility and educational attainment, Puerto Rico, 1962. Washington, U. S. Dept. of Health, Education and Welfare, 1967.

Horwitz, Abraham
Health and progress in the Americas. Washington, World Health Organization. 1966

Industrial Medical Association.
Occupational Health Bookshelf. Chicago, Industrial Medical Association, 1968.

Koontz, Amos R.
Agenesis of the right half of the diaphragm. reprint: American Surgeon V. 34 No. 9, September 1968.

Kovacs, Helen
Historical review of medical libraries in Brooklyn. Brooklyn, Medical Research Library, 1967.

Liebman, Sumner D.
The pediatrician's ophthalmology; a collaborative effort of several authors. St. Louis, Mosby, 1966.

National Conference on Education and Career Development of the National Committee for Careers in Medical Technology, October 1967.
Manpower for the medical laboratory, a summary report. Washington, U. S. Department of Health, Education, and Welfare, 1968.

National Health Education Committee.
What are the pay-offs from our Federal Health Programs? A progress report on the Johnson Administration. New York, National Health Education Committee, 1968.

National medicolegal symposium, Miami, 1967.
Proceedings, jointly sponsored by the American Bar Association and American Medical Association March 9-11, 1967.

Pacific Coast Oto-Ophthalmological Society.
Transactions. V. 47 San Mateo, California, 1968.

Pathological Society of Great Britain and Ireland, London, 1967.
Symposium on mycoplasma. Held jointly with the Society for General Microbiology. Printed by Oliver and Boyd Ltd., Edinburgh, 1967.

Robinson, James Roper
Fundamentals of acid-base regulation. 3d. ed. Oxford, Blackwell Scientific Publications.

Robinton, Elizabeth D.
Paper towels vs. cloth towels. A study of bacterial contaminants of cloth and paper towels. New York, American Paper Institute, 1968.

Roos, Charles A.
Physicians to the presidents and their patients. A bio-bibliography. Chicago, Medical Library Association, 1961.

Sawyer, Kenneth Charles.
Management of foreign bodies in the food and air passages. Springfield, Ill., C. C. Thomas, 1967.

Seibert, Florence B.
DMSO and other combatants against bacteria isolated from leukemia and cancer patients. Pittsburgh, Cancer Research Foundation, 1967.

Sobotta, Johannes
Atlas of human anatomy. 8th English ed. by Frank H. J. Figge. New York Hafner Publishing Company, 1968.

Stein, Edward S.
Calibration of two bicycle ergometers, used by the health examination survey. Washington, U. S. Department of Health, Education, and Welfare, 1967.

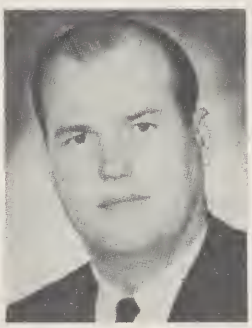
Taylor, Jean Anne M.
Special report on women and graduate study. Bethesda, National Institutes of Health, 1968.
U. S. Department of Health, Education, and Welfare. Secretary's Advisory Committee on Hospital Effectiveness.
Report. Washington, U. S. Department of Health, Education, and Welfare, 1968.
U. S. Library of Congress. Serial Division.
Popular names of U. S. government reports. Washington, Library of Congress, 1966.
U. S. National Cancer Institute.
Treating Cancer. U. S. Public Health Service, 1967.
U. S. Public Health Service. Division of Public Health Methods.
Health Manpower Source Book. Section 18. Manpower in the 1960's. Washington, U. S. Department of Health, Education, and Welfare, 1964.
U. S. Public Health Service. National Center for Urban and Industrial Health.
Solid waste/disease relationships. Report by Thrift G. Hanks. Cincinnati, U. S. Department of Health, Education, and Welfare, 1967.
Uniunea societătilor de Stinte Medicale din Republica Socialistă Romania.
Index al articolelor aparute în cursul anului 1967, în revistete medicale publicate de U. S. S. M. Bucharest, Editura Medicala, 1968.
Wassell, B. Bohdan
Group analysis. New York, Citadel Press, 1959.
Year book of obstetrics and gynecology. Chicago, Year Book Medical Publishers, 1968.



8521 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND
668-2300

Our experienced counseling assures complete and practical funeral service with concern for individual needs and desires.

JOHNSON
Funeral Home



WILLIAM E. JOHNSON

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ INGLESIDE SHOPPING CENTER
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ HILLENDALE SHOPPING CENTER
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

FREE GIFT For taking a test drive. Come in and inspect our beautiful new facilities.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL
5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

MEDICAL CENTER

to be built in

THRIVING SHOPPING CENTER

at

PERRING PARKWAY and McLEAN BLVD.

● All suites on ground floor ●

For information . . . . call

W. C. PINKARD & CO.

5 E. REDWOOD ST. BALTIMORE, MD.

PL 2-4285

"The Best of Care for Those You Love"



Pleasant Manor

CONVALESCENT AND NURSING CENTER

ONE OF THE NEWEST, MOST MODERN PARA-MEDICAL FACILITIES

Round-the-clock care by Professional Staff
Complete Intensive Care Units
Physical and Occupational Therapy

Excellent Meals--Kosher Food on Request
Air-Conditioned, Fire-resistant Building
Centrally Located Near Sinai Hospital
Your Inspection Invited

4615 PARK HEIGHTS AVE. BALTIMORE, MD. **542-4800**

when treatment requires

MOIST HEAT

for the relief of pain



Suggest the Battle Creek

THERMOPHORE

Arthritis? Rheumatism? Aches from Flu, Colds, Sore Muscles? Enjoy oh-so-soothing **relief!** Apply pain-relieving **moist heat** with a wonderful Battle Creek **Thermophore.**
Easy to use. Just "snap the switch." Gives relaxing pain-soothing moist heat in seconds! Use no water. No Messy "wet packs." You've never felt help like this!

Phone for Free Descriptive Literature, or See It At . . .

THERAPEUTIC APPLIANCES, INC.

JULES MORSTEIN

1114 Light St. **Phone 752-6996**

Baltimore Md. 21230

Distinguished Dining

Whenever the holidays,
Whatever the reasons,
It's the

Olney Inn

The Inn for all seasons.

And for an "Adventure in Shopping," be sure to visit the Inn's BARN SHOP. Antiques, Reproductions, Imports, Contemporary Gifts.

30 minutes from downtown Washington

Rte. #97 – Georgia Ave., Olney, Md.

From Baltimore, Rte. #29—#108—#97

For Reservations — Phone: 929-1717

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Influenza 1968-69

Hong Kong influenza, that is, A2/HK/68 was first recognized in Maryland among the students of a Baltimore college during the week beginning November 25. The onset of this outbreak was during the second week in November. Since then, reports of increasing prevalence of the influenza-like illness have come in from all parts of the city and the state. The spread of the outbreak in the counties lagged a week or ten days behind Baltimore. It appears that the peak was reached in Baltimore city during the week beginning December 16 and in most of the counties during Christmas week. By the third week in January the outbreak was in a definite decline throughout the state, as evidenced by school and industry absenteeism which have almost without exception returned to normal for this season of the year. School authorities report the elementary school age groups have not been greatly involved and the attack rates were highest among young adults. It is interesting to note that the University of Maryland at College Park with 32,000 students, up to the time of its closing for the Christmas holidays, experienced no marked increase in upper respiratory illnesses. On the other hand, there were definite outbreaks in the Naval Academy in Annapolis, the University of Maryland Medical School, the personnel in the State Health Department, and in several industries.

The illness is characterized by the usual classical symptoms of influenza. Fever up to 104, headache, pharyngitis, myalgia were the chief symptoms. Lung involvement seemed to be less than in previous outbreaks. In many instances, complete recovery was slow. Although deaths from influenza and pneumonia have not been grouped by age, there is a preponderance in the upper age groups; and the weekly number of deaths for the whole state reached a record peak of 78 during the week ending January 12.

The presence of Hong Kong influenza virus was documented on November 30 both serologically and bacteriologically. Since then, the virus has been isolated from some 50 cases from Baltimore city, Anne Arundel, Baltimore, Charles, Prince Georges, Montgomery, and Frederick counties. No specimens have been examined from the Eastern Shore, although the disease was prevalent there during the latter part of December.

Anticipating a shortage of the monovalent A2/HK/68 vaccine, the Communicable Disease Division, in early November, advised all local health departments and state-administered hospitals to place orders through the Health Department for sufficient vaccine to immunize high-risk inmates and staff. On the basis of these requests, 12,000 doses were ordered and delivery made on December 5. This was immediately distributed to the various institutions. Unfortunately, some of the institutions failed to request the vaccine, and for this reason were not able to immunize until an additional supply was received on December 27. The shortage was nation-wide, and many physicians failed to obtain supplies before the second week in January. At the present time, the vaccine is available throughout the state.

Although the epidemic is on the wane, new cases will continue to occur for several weeks. As to whether or not there will be a recrudescence in the coming months is impossible to say. The Health Department is recommending, however, that all persons in the high-risk groups be given the Hong Kong vaccine.



BOLTON HILL *Dinner Theatre*

"LUV"
Through April 6

"YEARS AGO"
April 8 — May 4

Dinner Theatre—7 P.M.
Dancing 11 P.M.-2 A.M.

FREE VALET PARKING

CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
11:30 AM - 2 AM
DINNER SERVED
5 PM - 10 PM

for Reservations
call 728-0800

Luncheon Served 11:30 AM-2 PM

Baltimores Only Professional Dinner Theatre

4 Extra Pay Checks

a year with our
Higher Dividend
Paid Quarterly

Open a Savings Account Now!

Chesapeake Federal

SAVINGS & LOAN ASSOCIATION
2240 EASTERN AVE. Corner PATTERSON PARK
ORLEANS 5-6602

- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE
EVANGELICAL
PRESS
THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions
Through Good Impressions"

Offering 2 GENERATIONS of research and experience in cooperation with the MEDICAL PROFESSION

CORRECT SHOES

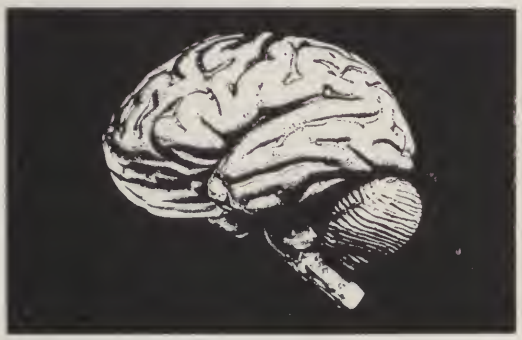
for every Rx need

Normal	Pronators
Straight	Supinators
Corrective	D. B. Splints

Modifications and Custom Work

HERBERT COX

HU 4-0021	SA 7-7883
1433 Reisterstown Rd.	210 N. Liberty St.
Pikesville 21208	Baltimore 21201



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Is There A Revolving Door?

Data from Maryland's five state-operated mental hospitals indicate that the concept that most alcoholics have a continuing series of admissions is not based on fact. During the year ending June 30, 1967, 3,690 persons had a total of 5,166 admissions to these facilities in which they received a primary diagnosis of alcoholism. Of these 3,690, 2,800 (or 75.9%) were hospitalized once during this 12-month period and 578 (or 15.7%) were admitted twice. Only 66 (or 1.8%) had five or more admissions. Further, 1,521 (or 41.2%) of all patients were admitted once during this year and had not been previously hospitalized in a psychiatric facility.

The distribution of these individuals by race, sex and number of admissions is shown in the following table:

	Total	White Male	White Female	Nonwhite Male	Nonwhite Female
Number of Admissions	5,166	3,349	481	1,176	160
Number of Persons Admitted	3,690	2,279	358	904	149
1 Admission	2,800	1,675	276	709	140
2 Admissions	578	374	58	139	7
3 Admissions	170	116	13	39	2
4 Admissions	76	56	7	13	–
5 Admissions	34	27	3	4	–
6 Admissions	17	17	–	–	–
7 Admissions	5	4	1	–	–
8 Admissions	6	6	–	–	–
9 Admissions	3	3	–	–	–
10 Or More Admissions	1	1	–	–	–
Rate *	163.3	242.2	36.7	548.8	87.0

* Number of persons admitted per 100,000 estimated population 18 years of age or older in specified race-sex group.

Proportionally, nonwhite rates were more than twice as high as comparable figures for both white males and females. In part, this was related to the greater availability and use by the latter group of alternate treatment resources. Also, Negroes have been hospitalized at an earlier stage of the illness. While 23.9% of the 904 nonwhite males were reported as acute alcoholics, 14.7% of the 2,279 white males received this diagnosis. Conversely, 64.9% of the nonwhite males and 77.1% of the white males were stated to be addicted to alcoholism. These figures appear to indicate varying incidence rates of the different levels of alcoholism as well as selective handling by police and other commitment sources.

Alcoholics are currently estimated to occupy one out of every nine state mental hospital beds and to account for a majority of all admissions. These figures represent a continuing, substantial increase in recent years. While it is not known whether or not these data reflect a growing total number of alcoholics, most of this rise in admissions for alcoholism has been concentrated in the age groups under 45. It would therefore appear that this upward trend will continue if present conditions persist. One possible alternative is the development of preventive programs, particularly among young state residents, concurrently with the large scale expansion of coordinated, community-centered treatment facilities.

YOUR HEADQUARTERS FOR
PHOTOGRAPHIC EQUIPMENT
. . . for Medical, Surgical, and Research Applications
Phone LE 9-5763
PHOTOCENTER
23 N. Howard St. Baltimore, Md. 21201

SKILL SURGICAL, INC.
SUPPLIES & EQUIPMENT
for
PHYSICIANS—SURGEONS
HOSPITALS
5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

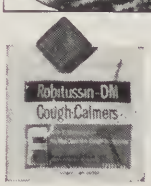
Achromycin V
250 mg. capsules

ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481D-9

INSECTS . . . TERMITES . . . RODENTS
"Call the Rose Man" Phone: 467-5300

ROSE
EXTERMINATOR CO.
"Call the Rose Man"
OVER 100 YEARS
3950 Falls Road, Baltimore, Md. 21211
F.H.A. INSPECTIONS — PRETREATMENTS
Prompt—Discreet—Efficient
SERVICE





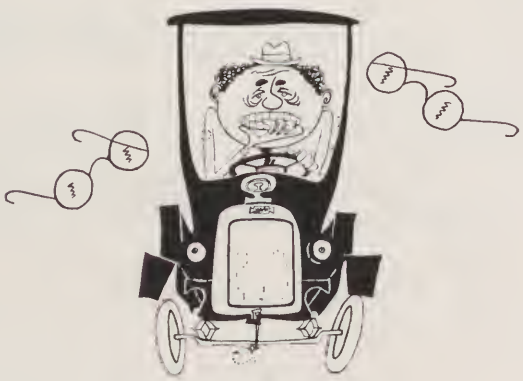
Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220
A·H·ROBINS

Are Your Patient's Eyes Fit For Driving a Car?

SOLOMON E. BARR, MD
Silver Spring, Maryland

On today's high-speed highways the driver is pressed for quick reactions mile after mile, his eyes constantly shifting from the often poorly lit road ahead, to his instrument panel, to his rear view mirror. How well can he see? Until this past year the visual standards for Maryland drivers were the lowest in the United States.

The AMA Committee on Medical Aspects of Automobile Injuries believes that vision in one eye should be 20/40 or better.[1] Until July 1, 1968, people in our State received licenses to drive when vision was only 20/70 in the better eye. Over a period of years their vision may have further deteriorated but they may still have an unrestricted license. The new law requires that a driver must have vision in each eye of at least 20/40.[2] If he has only monocular vision, bilateral side mirrors must be employed. People with recent loss of vision in one eye are prohibited from driving for 90 days.[2]



For safe driving, a motorist must possess some lateral perspective in order to pass other vehicles or to see people or machines approaching from the side. A visual field of 140° or better is required.[1] Dark adaptation and susceptibility to glare are of great importance in night driving. Of course, dark glasses should not be worn at night and the windshield not tinted more than one-third from the top. At the present time, because of standardization of traffic lights, it is doubtful that color blindness is of great consequence.[1]

People should have their eyes checked regularly, and the Department of Motor Vehicles should know about drivers who are almost blind. Correct glasses must be worn and any necessary extra mirrors affixed to the car. We physicians can play a role in the reduction of traffic accidents by "seeing" that our patients see well enough to drive.

REFERENCES

1. "Physicians Guide for Determining Driver Limitation," AMA Committee on Medical Aspects of Automotive Safety, Chicago, Illinois, 1968.
2. House Bill No. 987, 1968 Maryland General Assembly.

———O———

From the Subcommittee on Traffic Safety of the Medical and Chirurgical Faculty of the State of Maryland

Medical Building Planned For North Avenue Site

Madison Park Professional Center, Inc., a newly formed corporation sponsored by nine Baltimore doctors, has announced plans to build a medical center on the northeast corner of North Avenue and Eutaw Place in the Madison-Park North Urban Renewal Area.

The center, a one-story L-shaped building, will face the North Avenue, Eutaw Place corner and offer ground-level pedestrian access through a landscaped plaza to medical suites for eight physicians and two dentists, a medical laboratory and an ethical pharmacy.

Completion of the center is anticipated by this spring.

The sponsors of the new corporation and its building venture are: William R. Birt, MD, Herbert Garland Chissell, Jr., MD, John T. Chissell, MD, Raymond L. Gray, DDS, Claude D. Hill, MD, Benjamin J. Kimbers, Jr., DDS, Archie Robinson, Jr., MD, Oakley H. Saunders, MD, and Richard Tyson, MD.



WHEN YOUR PATIENTS NEED NURSING CARE

Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED

24 HOUR SERVICE ESTABLISHED 1935

BALTIMORE, MARYLAND 21229

COLOSTOMY
ILEOSTOMY

Appliances and Disposable Bags

CALL

FIELDS PHARMACY

IN PIKESVILLE

for convalescent supplies and service

FOR RAPID DELIVERY **486-3300**

HIGHLAND HOSPITAL

Asheville, North Carolina

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational aotivities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, *Coordinator of Admissions*

or

Charles W. Neville, Jr., M.D.

Assistant Professor of Psychiatry and Medical Director

Area Code 704—253-2761



MRS. HARRY L. BERMAN, EDITOR

woman's auxiliary

Twentieth Annual Convention — Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland

Wednesday and Thursday, April 9 and 10, 1969

HEADQUARTERS—BELVEDERE HOTEL

Charles and Chase Streets, Baltimore, Maryland

Preliminary Program

Wednesday, April 9

Noon-6:00 PM Hospitality Room open
2:00 PM Registration, Red Room
Mrs. John G. Ball, Chairman
2:30 PM Pre-Convention Board Meeting
Mrs. H. Leonard Warres, President, presiding
6:00 PM Hospitality Night, Charles Room
Faculty and wives invited

Thursday, April 10

9:00 AM-6:00 PM Hospitality Room open
8:30 AM Past President's Breakfast, Maryland Room (2nd floor)
9:00 AM Registration
10:00 AM General Session, Assembly Room. Theme: Youth and Violence, (All wives of physicians—members and non-members of the auxiliary—are cordially invited to the General Session and Social Functions)
Mrs. Warres, presiding
Prayer and Pledge
Mrs. Wallace H. Sadowsky, President-Elect
Greetings
Richard A. Young, MD, Chairman, Public Relations Committee, Medical and Chirurgical Faculty, Advisor to the Auxiliary
Response
Mrs. DeWitt E. DeLawter, 1st Vice-President
Presentation of Convention Chairmen
Mrs. Henry P. Laughlin and Mrs. Charles Herman Williams
Roll Call of Delegates
Mrs. Raymond M. Yow, Recording Secretary
Convention Rules of Order
Mrs. Otto C. Brantigan, Parliamentarian
Credentials
Mrs. Karl F. Mech, Chairman
Minutes of the 1968 Semiannual Meeting
Mrs. Brantigan, Chairman, Reading Committee
Report of Treasurer
Mrs. Sullins G. Sullivan
Presentation of Budget
Mrs. M. McKendree Boyer, Finance Chairman
Amendments to Bylaws
Mrs. Emerson C. Walden, Chairman, Revisions and Resolutions
Necrology
Mrs. William N. Thomas, Jr., Chairman
Introduction of Honored Guests
Mrs. Warres
Presentation of Presidents of the Component Auxiliaries (reports distributed at the meeting)
Presentation of Auxiliary Officers and Committee Chairmen, 1968-69 (reports distributed)

Special Reports
Mrs. James S. Potyka, President, University of Maryland Chapter Woman's Auxiliary to the Student AMA (WASAMA)
Ad Hoc Committee on Children and Youth
Mrs. Harold P. Biehl, Chairman
Report of the President
Mrs. Warres
Courtesy Resolutions
Mrs. Archie R. Cohen, Chairman
Reports of the Nominating Committee
Mrs. Boyer, Chairman
Election of Officers
Installation of Officers
Mrs. Clifton C. Long, President, Woman's Auxiliary to the AMA
Presentation of Gavel
Mrs. Warres
Inaugural Address
Mrs. Sadowsky

11:30 AM Sherry Hour, Ballroom (12th floor)
Mrs. Andrew J. Brennan, Hospitality Chairman

12:30 PM Luncheon: Reservations for tickets ($3.75) must be received by the chairman, Mrs. Sullins G. Sullivan, by April 3.
Reservations limited, doctors invited.
Invocation
Rabbi Jeffrey B. Stiffman, Baltimore Hebrew Congregation
Presentation of Honored Guests
Mrs. Warres
Greetings
Arthur G. Siwinski, MD, President, Medical and Chirurgical Faculty
Guest Speaker
Mrs. Clifton C. Long, Ozark, Arkansas, President, Woman's Auxiliary to the AMA
Panel on Youth and Violence
Moderator: Mrs. Eleanor Arnett Nash, *Sunpapers* columnist.
Participants: James D. Drinkard, MD, psychiatrist, Sheppard & Enoch Pratt Hospital, Maryland Training School for Boys
Major/Adjutant General of Maryland General George Gelston
Mr. George S. Wills, Public Relations Director, The Johns Hopkins University, member of President's Commission on Violence
Presentation of Awards
Mrs. Wilson P. Smith, Eastern Regional Chairman AMAERF
Mrs. Elmer G. Linhardt, Chairman AMAERF
Presentation of President's Pin
Mrs. Warres
Presentation of Past President's Pin
Mrs. William S. Stone, Immediate Past President
Adjournment

3:00-5:00 PM Post Convention Board Meeting, Dixie Room (2nd floor)
Mrs. Sadowsky, President, presiding

6:15 PM Medical and Chirurgical Faculty Annual Reception and Presidential Dinner, Ballroom (12th floor)

DOCTORS SUPPLY COMPANY

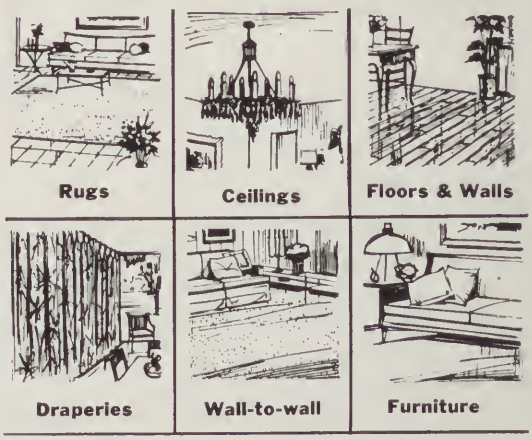
All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222



TRUST CHESAPEAKE
To Clean Them All!

*Service*MASTER specifications for carpet and furniture cleaning are recommended by leading carpet mills and furniture manufacturers nationwide. TRUST CHESAPEAKE for expert cleaning of office wall-to-wall carpeting, rugs, furniture, draperies, ceilings, floors, walls. 488-3000

CHESAPEAKE
Rug & Drapery Cleaners



The MEDICAL and CHIRURGICAL FACULTY
of the State of Maryland

ACCIDENT AND HEALTH PROGRAM FOR FACULTY MEMBERS

- **ACCIDENT AND SICKNESS TOTAL DISABILITY**
- **MAJOR MEDICAL EXPENSE**
- **ACCIDENTAL DEATH AND DISMEMBERMENT**

Administered by
THE MED-CHI INSURANCE TRUST

Official Faculty Agent
B. Dixon Evander and Associates

Underwritten by
Hartford Accident and Indemnity Company

Member of
The Hartford Insurance Group
Hartford, Connecticut

For more information detach and mail slip directly to:

MED-CHI INSURANCE TRUST
1211 Cathedral Street, Baltimore, Maryland 21201

*Name*_____

*Address*_____

*City and State*_____ *Zip Code*_____

ETHICS CORNER

Some physicians have raised the question as to whether they may charge interest on overdue accounts. In fact, some printers of physicians' bills have made this suggestion to physicians.

The AMA's code of ethics provides that physicians should derive their income solely from the rendering of professional services. In addition, the same code indicates that physicians should not impose undue hardship on patients when they fail to pay their bill within a prescribed period of time.

The specific statement reads:

"It is not in the best interest of the public or the profession to charge a penalty if fees for professional services are not paid within a prescribed period of time, nor is it proper to charge a patient a flat collection fee if it becomes necessary to refer the account to an agency for collection."

Part of the same Judicial Opinion reads as follows:

"Since the practice of medicine is a profession and not a business, the practices adopted by businesses are not necessarily suitable."

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

Do Your Patients Need Nursing Service?
Call **889-5666**
COBB-WOODS SERVICES
Vera Woods, M. A. Director.
2213 St. Paul St. Baltimore, Md. 21218
Licensed by the State of Md.

Al-Lin Ambulance Service
"AT THE BELTWAY"
4811 E. LEEDS AVE. BALTIMORE, MD. 21227
24 Hour Emergency Ambulance and Oxygen Service
Trained and Experienced Personnel
2 Way Radio Controlled
247-2111

BALTIMORE OXYGEN SUPPLY CO., INC.
OHIO CHEMICAL DISTRIBUTORS
Therapy and Medical Gases
Oxygen Tents
Resuscitators and Apparatus
PHONES: 789-8100 727-4748
Main Office and Plant
LINTHICUM, MARYLAND 21090

MARYLAND—DISTRICT OF COLUMBIA SOCIETY OF ANESTHESIOLOGISTS

SYMPOSIUM ON

ACUTE RESPIRATORY FAILURE

Holiday Inn Downtown, Howard & Lombard Sts., Baltimore

Saturday, May 17th, 1969 9:00 AM to 6:00 PM

9:00-10:00 AM:	Demonstration of Ventilators
10:00-10:45 AM:	"Principles of Mechanical Ventilators." Leslie Rendell-Baker, MD, Professor and Chairman, Department of Anesthesiology, The Mount Sinai Hospital and School of Medicine, New York.
11:00-11:45 AM:	"Ancillary Methods—Inhalation Therapy, Humidification, Physical Therapy." Meyer Saklad, MD, Anesthesia Research Department, Rhode Island Hospital, Providence, R.I.
12:00- 2:00 PM:	Lunch
2:00- 2:45 PM:	"Medical Treatment of Acute Respiratory Failure." Reuben M. Cherniack, MD, Professor of Medicine, The University of Manitoba, Winnipeg.
3:00- 3:45 PM:	"Use of Respirators in Acute Respiratory Failure." Henrik H. Bendixen, MD, Department of Anesthesia, Massachusetts General Hospital and Harvard Medical School, Boston, Mass.
4:00- 4:45 PM:	Questions
5:00- 6:00 PM:	Demonstration of Ventilators

Registration Fee $15. (Residents $5.) Includes Lunch, Morning and Afternoon Coffee.

Make Checks Payable To: Maryland—D.C. Society of Anesthesiologists

And Send To: T. Crawford McAslan, MD
Dept. of Anesthesiology, Univ. of Md. Hospital
Redwood & Greene Sts., Baltimore, Md. 21201



Patio — Garden —
Terrace Shops — Nursery
Indoor-Outdoor designs —
Landscaping
Casual furniture Gifts
for all occasions.

ValleyMart

6241 FALLS ROAD
VA 5-2500

A & F Nurses Registry



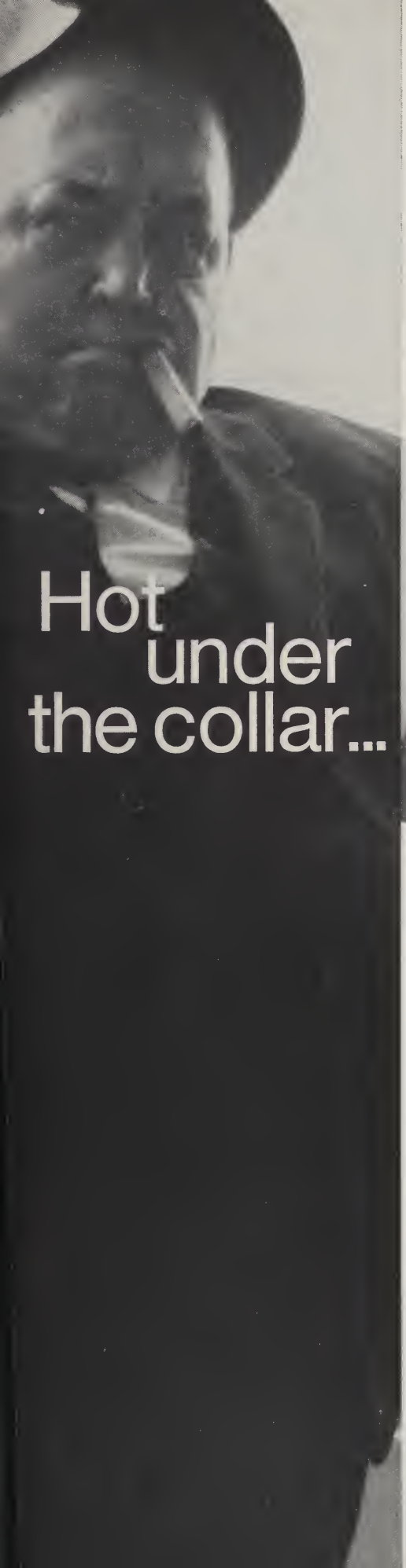
Registered & Licensed

LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.
BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218



Hot under the collar...

high under the cuff.



Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

the "Action" gap

Of the more than 100 different types of cancer, colon and rectal cancers are unique for two compelling reasons:

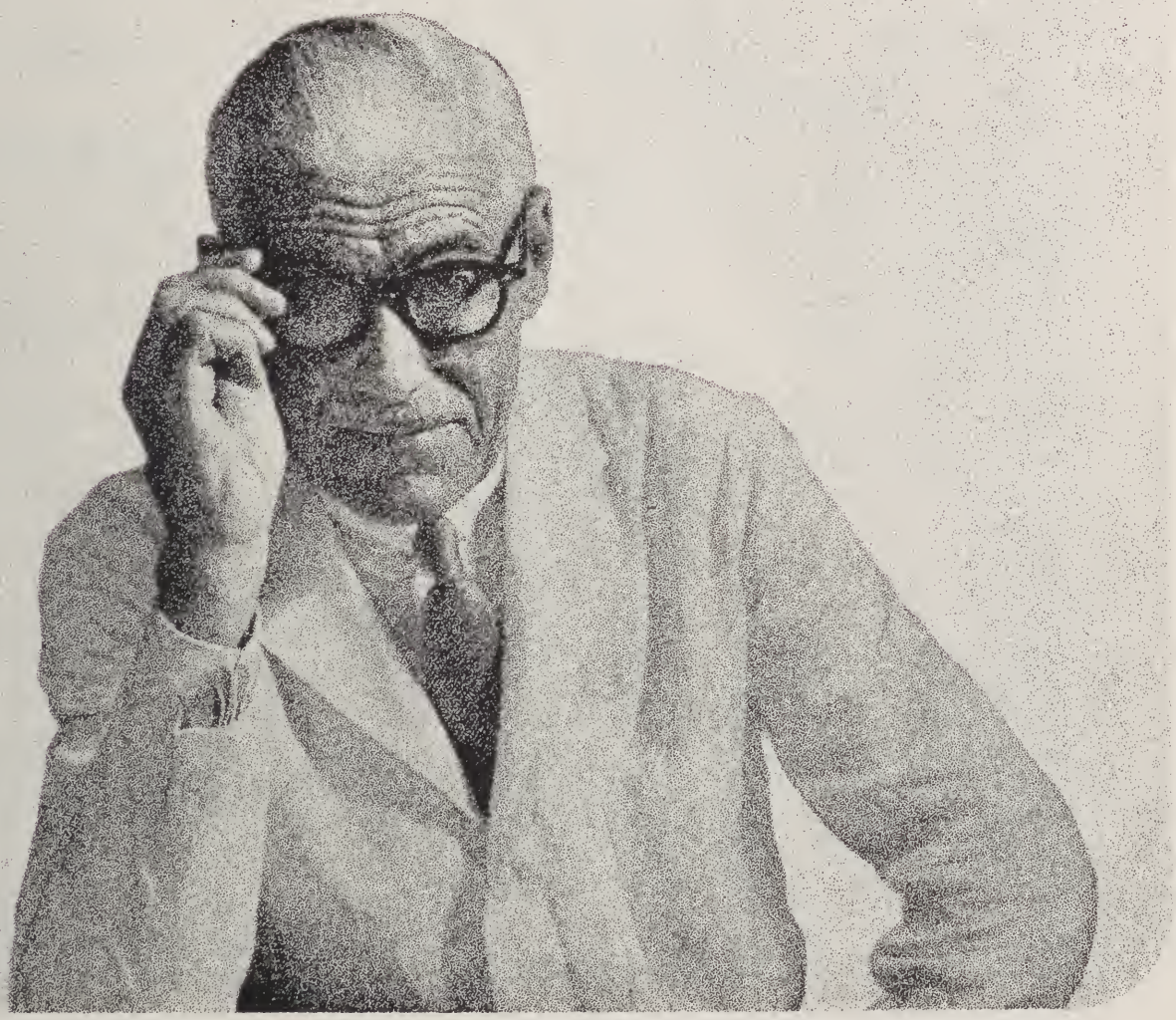
High incidence:	Annual new cases number about 73,000. Deaths now total 46,000 a year.
High curability potential:	Early diagnosis and prompt treatment could save almost 75%. Survival rate is now only 44%.

How to close the critical gap between possible and actual survivals?

The "procto" can today help save more lives from cancer than any other step in the checkup. Which is why, in our constant emphasis on the importance of annual checkups, we urge the inclusion of a "procto" ...and make available films and other pertinent materials for the layman and the physician. We *are* closing the "communications" gap.

Joint action by people and their doctors can help close the "action" gap to reach a cure rate of almost 75% for colon and rectal cancer.

American Cancer Society®



Classified Advertising

POSITIONS AVAILABLE

GENERAL PRACTITIONER WANTED—For vacation relief, 2-4 weeks April, May or June. Western Maryland area. Salary. Home provided. Send resume to: Box #4, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

ADMINISTRATIVE SENIOR MEDICAL HOUSE OFFICER—Responsible for supervising Medical Interns. No night duty. References and personal interview required. Salary open, depending on qualifications. Position available July 1, 1969 or sooner. Apply: Director of Medical Education, Franklin Square Hospital, Balto., Md. 21223.

ANESTHESIOLOGIST WANTED—Board eligible or certified. Fee for service. Practice in 300-bed general Hospital. Send resume to: Box #6, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

POSITION WANTED

OBSTETRICIAN-GYNECOLOGIST—Board certified; interested in doing locum tenans work in Maryland or the District of Columbia. For details, write to: Box #7, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

FOR SALE

GP'S OFFICE FURNITURE & EQUIPMENT—From well-equipped office—waiting room, 2 treatment rooms, consultation room, lab. Also, Sandborn EKG and ultrasonic machine, small autoclave, and miscellaneous instruments. Call: AP 7-1500 (Hyattsville).

LENS SET—Reasonable. Call: 833-2707 (Reisterstown).

EXAM TABLE—Hematrocrit & EKG machines, ice box, scale, microscope, autoclave, and furniture. Almost new. Write to: Box #8, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

"Truth" in Cigarette Packaging

America's physicians are overwhelmingly in favor of strengthening the health caution on cigarette packages and are for stricter control of cigarette advertising.

Their feelings, announced as the result of a recent Marion Laboratories Playback Poll, are in substantial agreement with the American Cancer Society, the Federal Trade Commission, and the U. S. Public Health Service, which are attempting to influence the Congress to pass laws which would put stricter curbs on cigarette labeling and advertising.

This poll includes the opinions of 1,156 doctors across the country.

Seventy-six percent of all the doctors polled—and 85% of the cardiologists—favored the stricter cigarette controls, while only 17% disagreed.

These findings are in close agreement with a poll conducted by the American Cancer Society, which found that 66% of the public agreed that a health warning should be required in cigarette advertising, while 48% were for stronger words in the health caution in cigarette packages.

CLASSIFIED ADVERTISING

Effective May 1, 1963

$1.50 per line per insertion

Count seven average words to each line. Add one line if box number is desired.

Members of the Medical and Chirurgical Faculty shall be entitled to one complimentary insertion in any twelve-month period. Widows of members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment.

MARYLAND STATE MEDICAL JOURNAL
1211 Cathedral St., Baltimore, Md. 21201

Advertisers in This Issue

Abbey Rents 98
A & F Nurses Registry 131
Alcazar Hotel 34
Al-Lin Ambulance Service 130
Ann-Lee Laboratories, Inc. 114
Arundel Federal Savings & Loan Assoc. 48
Baltimore Dictating Machine Co. 17, 18, 26
Baltimore Federal Savings & Loan Assoc. 12
Baltimore Nurses Exchange, Alice Weber 126
Baltimore Oxygen Supply Co., Inc. 130
Bolton Hill Dinner Theatre 122
Brentwood Inn 98
Bristol Laboratories 37
Broadview Restaurant 97
Burrows Wellcome & Co., Inc. 77
Campbell Soup Co. 41
Capital Savings & Loan Assoc. 130
Oscar Caplan & Sons 8
Central Dodge, Inc. 30
Chesapeake Federal Savings & Loan Assoc. 122
Chesapeake Rug Cleaning 128
Club Venus 97
Cobb-Woods Services 130
Cork 'n Bottle Restaurant 97
Herbert Cox—Correct Shoes 122
Dobbs House 97
Doctors Supply Co. 128
Dulaney Towson Nurs. & Conv. Home 110
Eagle Printing Co. 98
Eastern Research Laboratories, Inc. ..... 3rd Cover
Eleven East Chase St. Corp. 48
Embassy Dairy 76
Evangelical Press 122
Fedder's Medical Services 8
Federated Business Services, Inc. 16
Fields Pharmacy 126
Forty West Volkswagen 18
Franklin Uniform Co. 113
Geigy Pharmaceuticals 78-79, 82, 132-134
Globtrotter Travel 34
Hecht Co. Northwood Rooftop Restaurant 97
Hidden Brook 107
High Fidelity House 114
Highland Hospital 126
Hood Convalescent Home 48
House in the Pines Nursing Home 104
Humble Leasing Co. 95
Hynson, Westcott & Dunning, Inc. 1
International Pharmaceutical Corp. 46-47
Jobst 90
Johnson Funeral Home 119
Lederle Laboratories 3, 18, 19-20, 32, 116, 124
Eli Lilly & Co. 4
Maico Hearing Aids, Inc. 114
Maria's 300 Restaurant 97
McNeil Laboratories, Inc. 21
Mercantile-Safe Deposit & Trust Co. 24
Metropolitan Washington Blood Banks, Inc. 34
Michaelson Motors, Inc. 110
Miller Brothers Restaurant 97
Milton Inn 97
Monarch Lincoln Mercury, Inc. 119
Murray-Baumgartner Surg. Instr. Co., Inc. 11
National Drug Co. 13, 102
Olney Inn 120
Palmer House 97
Parke, Davis & Co. 99
Photocenter 124
Pielke Landscape Services 34
W. C. Pinkard & Co. 120
Pitman-Moore 22-23
Pleasant Manor Nursing Home 120
Wm. P. Poythress & Co., Inc. 100, 102
T. Rowe Price Growth Stock Fund, Inc. 48
Professional Management Co. 11
Geo. Radebaugh & Sons 108
Read's Drug Stores 119
Resinol Chemical Co. 89
R & H Motors, Inc. 76
A. H. Robins Co. 35-36, 40, 124
Roche Laboratories ..... 38-39, 80-81, 94-95, 4th Cover
Rose Exterminator Co. 124
Sakura Palace 18
G. D. Searle & Co. 42-43
Manuel Schwartz, Hearing Rehab. 76
Skill Surgical, Inc. 124
Smith, Kline & French Laboratories 45
Special Diet Shop 76
Sterling Lighting Co. 107
Strasenburgh Laboratories 44
Mano Swartz—Furs 8
Therapeutic Appliances, Inc. 120
Tijuana Tacos 97
Valley Mart 131
Valley View Farms Country Store 76
D. Stuart Webb Advertising Services, Inc. 76
Westview Lounge & Supper Club 97
White Rice Inn 97
Winthrop Laboratories 101
Wyeth Laboratories 14-15
Zimmermann's Shoes 8

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number, the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.



after surgery...

To restore tissue depletion of Vitamin B Complex and ascorbic acid induced by the physiological stress of surgery, illness or injury—Increases the recuperative power of convalescence.

beta massive capsules

B COMPLEX WITH VITAMIN C



Thiamine HCl	B_1	10 mg.
Riboflavin	B_2	10 mg.
Pyridoxine HCl	B_6	5 mg.
Cyanocobalamin	B_{12}	4 mcg.
Ascorbic Acid	C	150 mg.
Calcium Pantothenate		20 mg.
Niacinamide		50 mg.

EASTERN RESEARCH LABORATORIES, INC.

302 S. CENTRAL AVE. BALTIMORE, MARYLAND 21202



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiotric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulacytasis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

EADING
ROOM



NATIONAL LIBRARY OF MEDICINE
RECD. MAY 6 1969
INDEX
INPUT

JTC: LJY
INDEXER:
VOL-ISS: 18-4
DATE:
DEPTH:
NON-DEPTH:
RUSH:
SELECTIVE:

Maryland State Medical Journal

OFFICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

VOLUME 18, NUMBER 4
APRIL 1969

8600 ROCKVILLE PIKE
BETHESDA MD 20014

When your patient's world is shattered....



Taylor Manor Hospital

provides

Tomorrow's Mental Health

in

Today's Modern Hospital

Special Programs for:

Adults
Adolescents
Alcoholics
Narcotics and all
Nervous disorders



Accredited by
Joint Commission on Hospital Accreditation

Information and Rates,
Call or write
465-3322

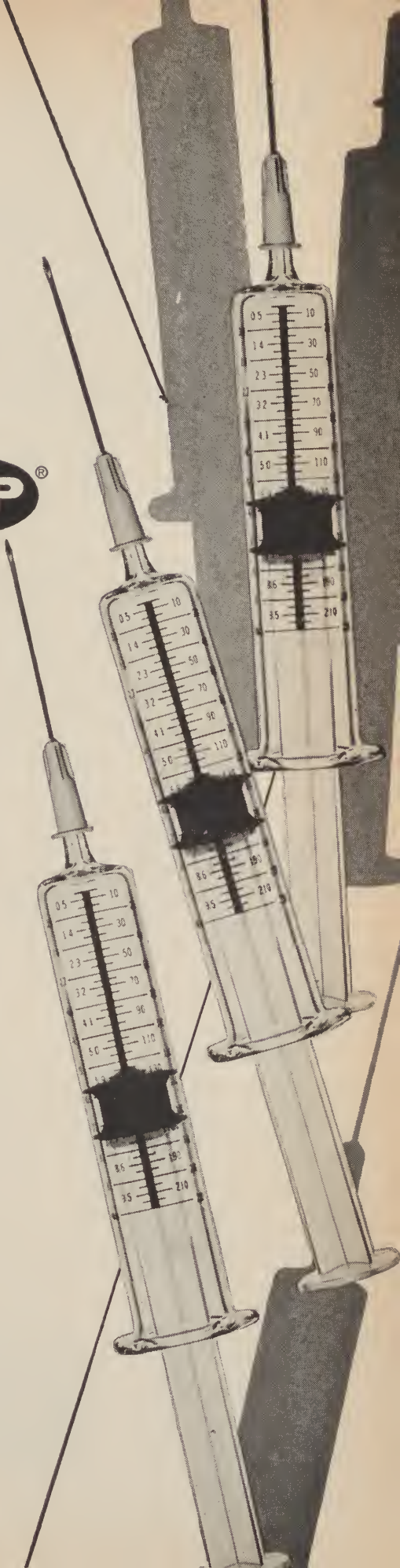
Taylor Manor Hospital
Ellicott City, Md. 21043

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)

BSP®



BROMSULPHALEIN®

IN A COMPLETE,

STERILE,

DISPOSABLE,

& ECONOMICAL

PATIENT-UNIT.

BSP, one of the more valuable single laboratory procedures for determining hepatic function, is now packaged in a complete individual patient-unit.

The BSP Disposable Unit contains a sterile syringe with the dosage schedule imprinted on the barrel, a sterile needle, alcohol swab and a 7.5 ml. or 10 ml. size ampule of terminally sterilized BSP solution. Each unit contains complete directions for use, precautions and contraindications.

This all-inclusive disposable put-up lessens the chance of cross-infection and saves time and labor — the most costly commodities.

HYNSON, WESTCOTT & DUNNING, INC.

(BSP03)

BALTIMORE, MARYLAND 21201

Maryland State
Medical Journal

VOLUME 18 APRIL 1969 NUMBER 4

CONTENTS:

Editorial—The Age of Aquarius 46
"The stars impel, they do not compel!
What you make of your life is largely up to you."

The Adolescent Patient: An Overview, Sheldon D. Glass, MD 48
"The 20th Century Adolescent is a topic which in recent years has stirred the interest and demanded the attention of the entire nation. We have had overt rebellion from our adolescents. They are demanding IN. They want a piece of the action."

Implications of the Sex Revolution in the Adolescent's Search for Sexual Identity, James F. Masterson, Jr., MD 53
"Perhaps the main implication of the sexual revolution is the fact that the topic is mentioned almost always in the course of everyday conversation. . . . Everyone has, or had, sexual conflicts in his development which he resolved to, perhaps, a relative degree. Still, he wants to know more about them. . . ."

Addiction, Psychodelic Experimentation and Abuse of Drugs by the Concerned Generation, Dale G. Friend, MD 59
"There have been discoveries of new (drug) substances in recent times. . . . The very nature of the action of these drugs makes it difficult to develop a true assessment of their action. It is very easy to be misled as to the effect. . . . For example, claims made by certain groups, that smoking dried banana pulp or peels gives a psychological effect, are without foundation. Such could either be a delusion resulting from a placebo effect, or a hoax put on the squares by the hippies."

Depression in Adolescents and College Students, Francis J. Braceland, MD, and Dana L. Farnsworth, MD 67
"Despite the fact that depression has been recognized for over two thousand years and is the psychiatric diagnosis most frequently made today, there is much about it that remains enigmatic."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 75
Ethics Corner—Malpractice Alert 78
Rehabilitation Notes—A Therapeutic Approach to Osteoarthritis, James M. Sowa, MD 97
Maryland State Department of Mental Hygiene—Admission Rates at Record Level in all Age Groups 100
Tuberculosis—Treatment of Disseminated Mycotic Infections 101
Baltimore City Health Department 103
Heart Page—Wolff-Parkinson-White Syndrome, John J. Messina, MD 105
Maryland State Department of Health—Highlights 109
Traffic Safety—Emergency Medical Services, Perry Stearns, MD 115

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301). ©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland. Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

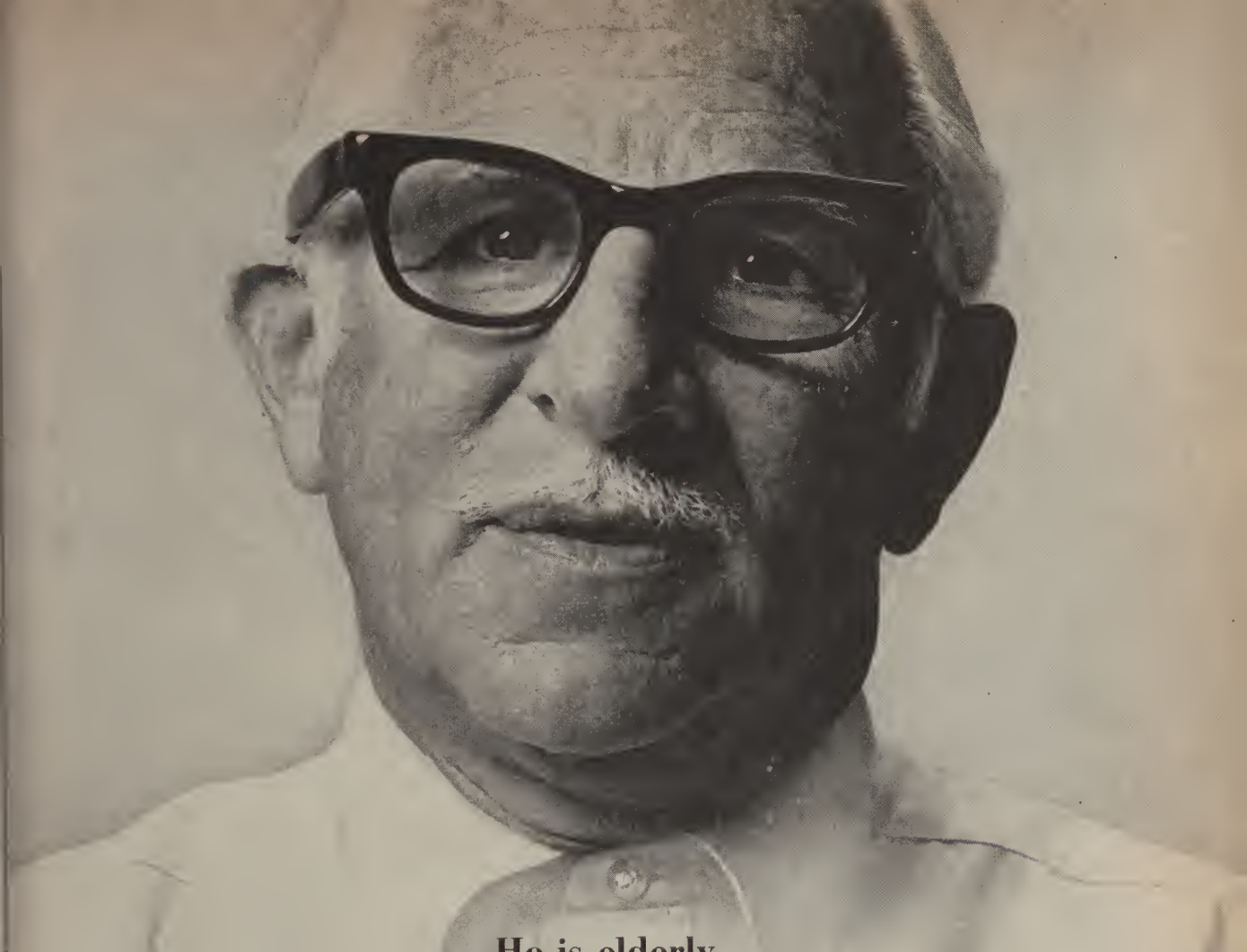
EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

ON THE COVER: When the term adolescent crops up in conversation these days, we usually expound on the negative aspects of the group. Even though all young adults are not rebellious, dirty, sloppy and addicted to drugs, the problems presented by the speakers at the Geigy Symposium on the 20th Century Adolescent (pp 48-73) are those which are, and have been, most readily observed. Photograph by Frank Spinek, courtesy of the News American.

Doctors Take Note 5
Executive Secretary's Newsletter 13
Book Reviews 17
Board of Medical Examiners 25
MEDIC 29
Semiannual Meeting 31
Medical News 79
Information for Authors 82
Component Societies 83
Month in Washington 88
Anesthesia Meeting 96
Woman's Auxiliary 117
Library Accessions 121
The Name of the Game 128
Fellowship Opportunities 131
Classified Advertising 134
Advertising Index 135



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

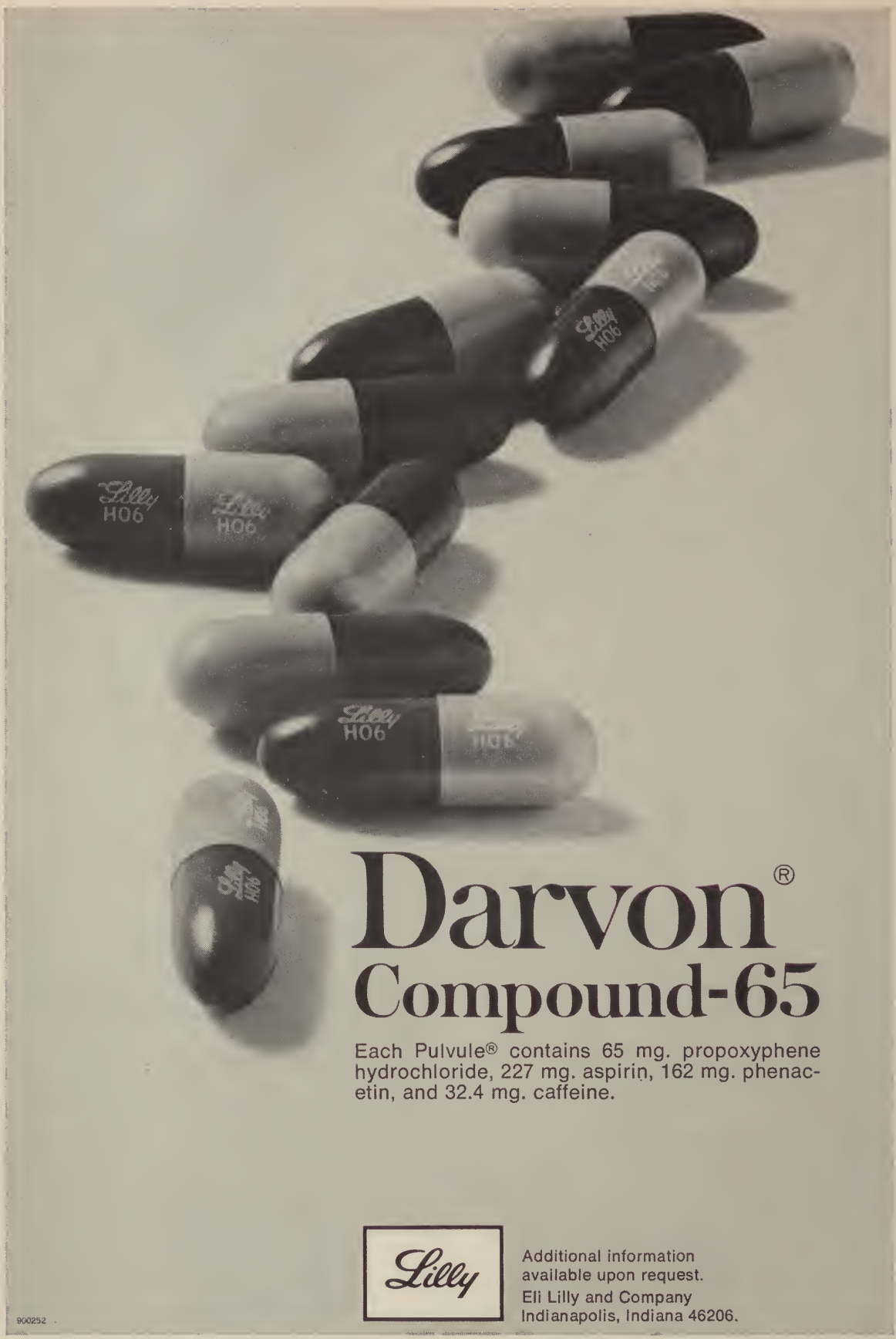
Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York


Lilly
H06
Darvon®
Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.
900252

Doctors take note...

APRIL 20-26, 1969
INTERNATIONAL COLLEGE OF SURGEONS

First Clinical Seminar On Obstetrics And Gynecology: Chicago. Program subjects include: radical pelvic surgery—abdominal and vaginal approach; pelvic surgery for non-malignant conditions, including stress continence, urological fistulae in gynecological patients and pelvic hernias; and endometriosis —medical, surgical and hormonal treatment. Contact: The International College of Surgeons Headquarters, 1516 North Lake Shore Drive, Chicago, Ill. 60610. Phone (312) 642-3555.

APRIL 21-23, 1969
AMERICAN ACADEMY OF PEDIATRICS

Annual Spring Session: Sheraton-Boston Hotel, Boston. Contact: Department of Public Information, American Academy of Pediatrics, 1801 Hinman Ave., Evanston, Ill. 60204.

APRIL 21-24, 1969
INDUSTRIAL MEDICAL ASSOCIATION/AMERICAN ASSOCIATION OF INDUSTRIAL NURSES

American Industrial Health Conference: Shamrock Hilton, Houston, Texas. Contact: American Industrial Health Conference Headquarters, 55 East Washington St., Chicago, Ill. 60602.

APRIL 23, 1969
MARYLAND KIDNEY FOUNDATION

Seminar in Renal Disease—Chronic Pyelonephritis in its Proper Perspective: 5 PM, University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. Speaker: Robert H. Heptinstall, MD, Professor of Pathology, The Johns Hopkins University School of Medicine.

APRIL 24-25, 1969
NEW YORK UNIVERSITY POSTGRADUATE MEDICAL SCHOOL

Theory and Practice of Contact Lenses: New York University Postgraduate Medical School, 550 First Ave., New York. Director: Donald A. Fonda, MD. Contact: Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N.Y. 10016.

APRIL 24-26, 1969
UNIVERSITY OF ILLINOIS, COLLEGE OF MEDICINE/AMERICAN COLLEGE OF CHEST PHYSICIANS

Postgraduate Course—Pulmonary Care In Children: Chicago. Contact: Charles L. Swarts, MD, American College of Chest Physicians, 112 East Chestnut St., Chicago, Ill. 60611

APRIL 25-26, 1969
MARYLAND RADIOLOGICAL SOCIETY

Annual Meeting: Statler Hilton Inn, Annapolis, Md.

APRIL 26, 1969
TAYLOR MANOR HOSPITAL

2nd Annual Symposium—Manipulating and Controlling Human Behavior by Drugs—Present and Future: Taylor Manor Hospital, Ellicott City, Md. Speakers: Frank J. Ayd, Jr., MD, Editor, *International Drug Therapy* Newsletter; Stanley F. Yolles, MD, Director, National Institute of Mental Health; Henry Brill, MD, Vice Chairman, Narcotic Addiction Control Commission of New York; Nathan S. Kline, MD, Director of Research, Rockland State Hospital, New York; Sidney Cohen, MD, Director, Division of Narcotic Addiction and Drug Abuse, NIMH; Milton Greenblatt, MD, Commissioner of Mental Health, Commonwealth of Massachusetts. Contact: Symposium Coordinator, Taylor Manor Hospital, Ellicott City, Md. 21043. (301) HOward 5-3322.

APRIL 28-30, 1969
AMERICAN DIABETES ASSOCIATION/JOSLIN DIABETES FOUNDATION

First Paramedical Postgraduate Course in Diabetes: Sheraton-Boston Hotel, Boston, Mass. Contact: American Diabetes Association, 18 East 48th St., New York, N.Y. 10017.

APRIL 28-MAY 2, 1969
NEW YORK UNIVERSITY POSTGRADUATE MEDICAL SCHOOL

Postgraduate Course—Ophthalmoscopy: New York. Director: George N. Wise, MD. Contact: Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N.Y. 10016.

APRIL 29, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conference—Home Hemodialysis: 4 PM, University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. 21201.

MAY 1-3, 1969
THE MOUND PARK HOSPITAL FOUNDATION/THE COLLEGE OF MEDICINE, UNIVERSITY OF FLORIDA

Symposium—Anxiety and Depression: Modern Interpretations: Tides Hotel and Bath Club, Redington Beach, Fla. Eighteen accredited hours by the American Academy of General Practice. Contact: Postgraduate Medical Education, Mound Park Hospital Foundation, Inc., St. Petersburg, Florida 33701.

MAY 5-8, 1969
NEW YORK UNIVERSITY POSTGRADUATE MEDICAL SCHOOL

Postgraduate Course—External Diseases of the Eye: New York. Director: Frederick H. Theodore, MD. Contact: Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N.Y. 10016.

MAY 7-9, 1969
NEW YORK UNIVERSITY POSTGRADUATE MEDICAL SCHOOL

Symposium and Course—Current Concepts in Clinical Oncology: New York. Director: Frederick M. Golomb, MD. Contact: Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N.Y. 10016.

MAY 8-10, 1969
AMERICAN CANCER SOCIETY/CANCER CONTROL PROGRAM, UNITED STATES PUBLIC HEALTH SERVICE

National Conference On Breast Cancer: Shoreham Hotel, Washington, D.C. Contact: Roald N. Grant, MD, National Conference on Breast Cancer, American Cancer Society, 219 East 42nd St., New York, N.Y. 10017.

MAY 12-16, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Internal Medicine: The Good That's Old; The New That's Vital: Einstein Medical Center Northern, and Temple University School of Medicine, Philadelphia, Pa. Director: Thomas M. Durant, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MAY 14-16, 1969
NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS, INC.

Annual Conference: Pfister Hotel, Milwaukee, Wis. Contact: Shel Sukoff, National Society for the Prevention of Blindness, Inc., 79 Madison Ave., New York, N.Y. 10016.

MAY 16-18, 1969
PENNSYLVANIA SOCIETY OF ANESTHESIOLOGISTS

Annual Meeting: Holiday Inn, Gettysburg, Pa. Contact: Chairman of the Program Committee, Herbert D. Weintraub, MD, University of Pennsylvania Hospital, 3400 Spruce St., Philadelphia, Pa. 19104.

MAY 17, 1969
MARYLAND-D.C. SOCIETY OF ANESTHESIOLOGISTS

Symposium—Acute Respiratory Failure: Holiday Inn Downtown, Baltimore, Md. Contact: T. Crawford McAslan, MD, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201.

MAY 17-21, 1969
THE MEDICAL SOCIETY OF NEW JERSEY

203rd Annual Meeting: Haddon Hall, Atlantic City, N.J. Contact: The Medical Society of New Jersey, 315 West State St., Trenton, N.J. 08618.

MAY 19-22, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Adolescent Medicine; University of Washington School of Medicine, Seattle, Wash. Co-Directors: James W. Haviland, MD, FACP; S. L. Hammer, MD; John Lien, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MAY 19-23, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Intensive Care Units: New York University and St. Vincent's Hospital, New York, N.Y. Co-Directors: William J. Grace, MD, FACP, and John J. Gregory, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MAY 20, 1969

UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conferences—Radioimmunoassay of Angiotension: 4 PM, University of Maryland Hospital, Psychiatric Institute, Room I-704, Baltimore, Md. 21201.

MAY 24-28, 1969

NEW YORK STATE ANNUAL HEALTH CONFERENCE

Sessions on various aspects of Environmental Health Problems: Lake Placid, N.Y. Participating is the State Action for Clean Air Committee. Contact: Newsletter, 105 East 22nd St., New York, N.Y. 10010.

MAY 26-28, 1969

COMMITTEE ON CONTINUING MEDICAL EDUCATION

Course—Medical Aspects of Radiological Health. This course includes demonstrations and laboratory exercises on patient protection, shielding and scattering of X-rays. Contact: John P. Adams, MD, Chairman, Committee on Continuing Medical Education, George Washington University Medical Center, 2150 Pennsylvania Ave., N.W., Washington, D.C. 20037.

- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

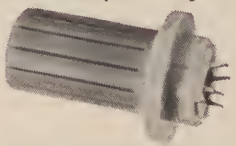
THE EVANGELICAL PRESS

THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.

How much does illness and lost time cost you?

KEX FLOOR PLAN PACKAGE —SERVICED BY RENTEX— IS EFFECTIVE AGAINST INFECTIOUS GERMS!

Read this Important News Now: — The U.S. Dept. of Agriculture has accepted the following claims for KEX Services:

- "KEX" Walk-Off-Mats are chemically treated with an anti-microbial additive to inhibit the growth and spread of environmental bacteria in a mat and to reduce contamination in the areas serviced by Walk-Off-Mats.
- "KEX" Walk-Off-Mats are effective against Staph Aureus.
- "KEX" Walk-Off-Mats reduce populations of air and dust-borne Staph Aureus in the areas serviced by Walk-Off-Mats.
- "KEX" Walk-Off-Mats reduce the introduction of bacterial populations in rooms serviced by Walk-Off-Mats.

Help clean the air for you and your employees. Let your Rentex Service expert show you how to minimize air borne bacteria with KEX Services. Act Now — TODAY! Call CE. 3-5700.

RENTEX SERVICES CORP.

RENTEX EASTERN OVERALL DIVISION

2804 WILKENS AVE., BALTIMORE, MD. 21223 • CE 3-5700

EASTON, MARYLAND ALEXANDRIA, VA.

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

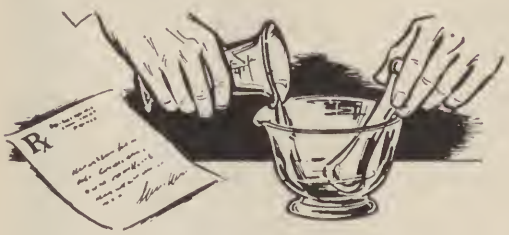
CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

BALTIMORE OXYGEN SUPPLY CO., INC.
OHIO CHEMICAL DISTRIBUTORS
Therapy and Medical Gases
Oxygen Tents
Resuscitators and Apparatus
PHONES: 789-8100 727-4748
Main Office and Plant
LINTHICUM, MARYLAND 21090

Do Your Patients Need Nursing Service?
Call **889-5666**
COBB-WOODS SERVICES
Vera Woods, M. A. Director.
2213 St. Paul St. Baltimore, Md. 21218
Licensed by the State of Md.



Patio — Garden — Terrace Shops — Nursery
Indoor-Outdoor designs — Landscaping
Casual furniture Gifts for all occasions.
ValleyMart
6241 FALLS ROAD
VA 5-2500



Your old friend
BELLADONNA
ALKALOIDS & PHENOBARBITAL

HYOSCYAMINE 0.30 mg. ATROPINE 0.06 mg.
HYOSCINE 0.02 mg. PHENOBARBITAL ¾ gr.

Now available in a long-acting capsule . . . . . .

For Sample and Literature
ANN-LEE LABORATORIES, INC.
P. O. Box 377
Randallstown, Md. 21133

Name .....
Address .....
.....
City State Zip

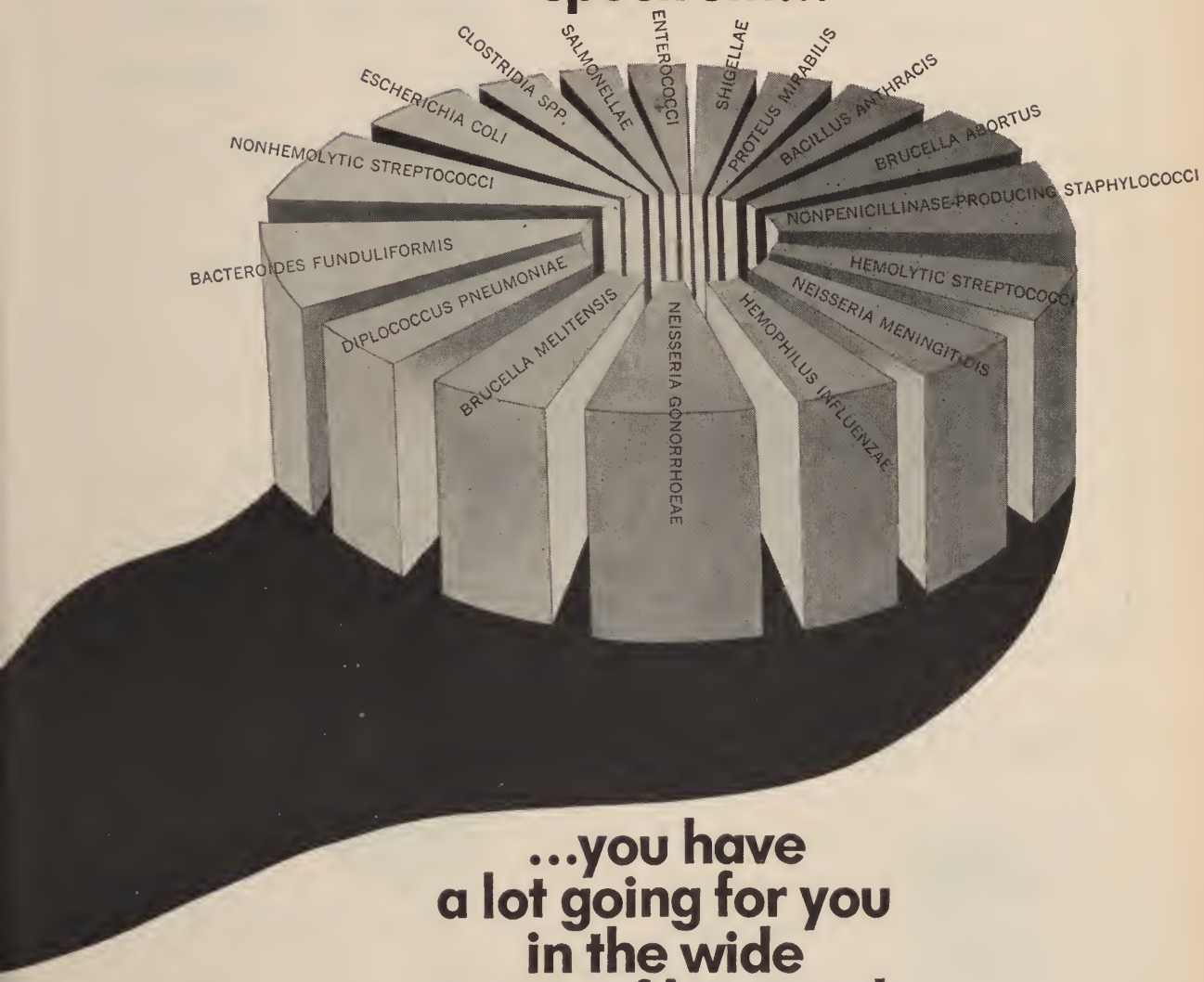
PHEN-BEL
CAPSULES

Your patient no longer has to worry about leaving his bottle of "pills" at home while at work. One PHEN-BEL Capsule in the morning and another at night for "round the clock" action.

The Cost is Reasonable

ANN-LEE LABORATORIES, Inc.
Randallstown, Md. 21133

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular.
Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).
Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.
Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.
Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.
Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.
Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.
11-1/2/69 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic

Specializing in the

fitting of shoes

for proper foot function

and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED

227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday
and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.

We recommend CAMP

PENDULOUS ABDOMEN SUPPORTS



Specifically designed to balance the load of forward bulk in obese patients; affords relief of strain on muscles and ligaments of the back and feet in the ankle-joints, caused by weight-accented spinal curve, bowed head and rounded shoulders. These supports often improve circulation and digestive disturbances.

DONALD O. FEDDER, ORTHOTIST

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

BALTIMORE, MD.

SPRING FASHIONS IN FURS



are more beautiful than ever

Exclusively in Maryland — fur designs by Oleg Cassini

Mano Swartz

LE 9-4900
225 N. HOWARD ST.



Oscar Caplan Original

Wye Oak Charm

Symbolizes the Wye Oak—official state tree of Maryland—emblematic of the Eastern Shore.

Sterling silver, $5.50.
14k gold, $24.50.
14k gold with hard-fired French enamel, $27.50.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

executive secretary's newsletter

April, 1969

EUROPEAN TRIPS PLANNED

Two European trips have been planned for the spring and fall of 1969. A trip to Vienna is scheduled for May 12 to May 18; and a trip to Spain for October 12 to October 21.

Full details may be obtained from Travel Guide Agency, 416 N. Charles Street, Baltimore, Md., 21201, or telephone SA 7-0682, Mrs. Beverly Wolins.

COMPLETION OF INSURANCE CLAIM FORMS

Physicians and their office assistants are urged to use caution in completing insurance claim forms. In the space provided for the physician's usual and customary fee, that charge should appear - - NOT THE AMOUNT ALLOWED BY THE CARRIER.

NAME CHANGE

The Baltimore Dermatological Society has officially changed its name to the Maryland Dermatological Society.

Current officers are:

Joseph W. Burnett, MD, President
M. Eugene Tudino, MD, Secretary-Treasurer

COMMISSION ON MEDICAL DISCIPLINE

Physicians are reminded that the Commission on Medical Discipline takes effect July 1, 1969. Guidelines for physicians in connection with the Commission are in the mail.

Any questions on the Commission should be directed to the Faculty office.

JCAH ACCREDITATION STANDARDS

Accreditation standards for the Joint Commission on Accreditation of Hospitals are presently under review. Preliminary revisions are now under study by a joint committee of the AMA and JCAH.

Two meetings have been held at which State Medical Society representation has been requested. Individuals from Maryland who have attended both sessions are Manning W. Alden, MD, Annapolis, Vice-chairman of the Faculty's Council; and Richard D. Bauer, MD, Adelphi, Past-president.

JCAH ACCREDITATION STANDARDS (cont'd)

Individuals interested in the revised standards or who wish to comment on them are urged to contact either of these two physicians.

LABORATORY BILLING RULING

In late February, Blue Shield indicated in a ruling that payment would not be made to physicians for services such as the drawing of blood or other specimens, indicating that the charge for such services are included in the physician's normal office visit fee.

The Faculty's Executive Committee has determined that the ruling adopted by the Council in June, 1965, is still applicable. The ruling is as follows:

"If a clinician and a laboratory share the responsibility for a laboratory procedure, each should send a bill for services rendered. No physician should be denied a reasonable fee for obtaining a specimen for testing purposes and/or interpreting the results of the test, but this should be itemized separately and appear on the physician's statement."

MED-CHI RETIREMENT FUND

The net asset value of the Med-Chi Members Retirement Fund has increased 19.09% for the period January 1, 1968, through December 31, 1968.

OSTEOPATHS

The Faculty office has been receiving an increasing number of inquiries regarding Osteopaths and the acceptance of such individuals who are licensed to practice medicine and surgery in Maryland. Briefly, the situation is as follows:

1. Such individuals can be accepted into medical society membership if eligible under the same standards applicable to Doctors of Medicine.

2. Such persons can be accepted into internship or residency training if either licensed in Maryland as indicated; or if they would be eligible for such licensure on completion of their training.

If further details are needed, please contact the Facuy office.

John Sargeant
Executive Secretary

YOUR NUMBER MAY BE UP

DOCTOR

◆

IT WILL BE FALSE ECONOMY
NOT TO BE ADEQUATELY
PREPARED

◆

YOUR
INCOME TAX RETURNS

MUST

BE SUPPORTED BY
ADEQUATE RECORDS

◆

OUR SERVICE
OFFERS YOU

MAXIMUM CONTROL AND SAFETY
FROM BALANCING RECORDS AND
MINIMUM EFFORT ON YOUR PART

◆

FINANCIAL MANAGEMENT
CAN HELP YOU

◆

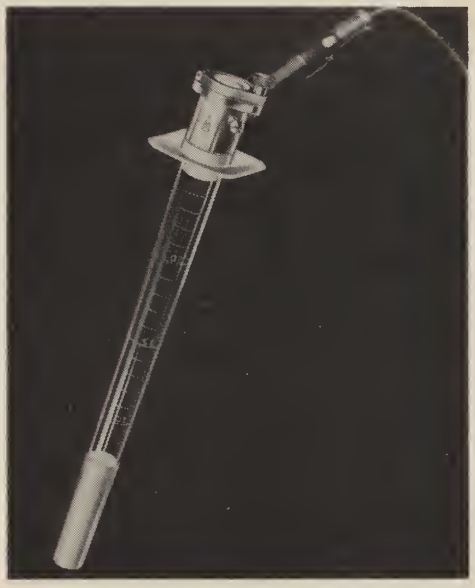
DIAL 752-5920

Professional Management Co.

914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN



New!

WELCH-ALLYN

KLEENSPEC

Fiber Optic—Disposable

SIGMOIDOSCOPE

SIMPLE

Both speculum and obturator are disposable. Speculum attaches instantly to permanent fiber optic light handle. No delicate or protruding light carriers to obstruct vision.

BRILLIANTLY ILLUMINATED

Light from a source in the handle is transmitted through the walls of the speculum emanating as a brilliant ring of light at the distall end.

TIME SAVING

Clean specula and obturators are always ready for instant use. No waiting for a KleenSpec.
Transparent, sealed envelope holds clean disposable speculum and obturator ready for use. May be gas sterilized.

Serving the Medical Profession
for almost Half a Century

Murray-Baumgartner

SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.

Phone: 669-9300 **Baltimore, Md. 21216**

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And fre your secretary to be your secretary again.

professional systems and services *division of*

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3886





FRANK BILLINGS, Edwin F. Hirsch, MD; published under the auspices of the Chicago Medical Society by the Printing Department, University of Chicago, 1966.

This biography of Dr. Frank Billings covers the entire span of his career and includes two brief commentaries on outstanding personalities known by the physician.

Dr. Billings was primarily responsible for the fusing of teaching medical students at Rush Medical College and the University of Chicago. He was well-known as an educator, innovator, and physician.

COOKING FOR YOUR CELIAC CHILD, Charlotte Baum Sheedy and Norman Keifetz; The Dial Press, New York, 1969.

This is the only gluten-free cookbook written to aid the parents of celiacs in preparing appetizing meals the whole family can enjoy eating together—and recipes for foods (using safe ingredients) which children most want and which are, in the usual composition, prohibited in a celiac's diet.

In addition to the over 300 specially developed and tested recipes, the authors have prepared a chapter, helpful to doctors and reassuring to parents, containing a full medical description of the disorder (including what is and what is not known about it), special psychological problems parents may encounter and how to deal with them, why and how to use the book. The book also contains lists of permitted and forbidden foods, recommended brand products found at supermarkets, sources for special health foods and foreign products, conversion tables for gluten-free cereal grains and flours and their equivalencies and characteristics, and a selected medical bibliography on the litrature in the field.

NURSES CAN GIVE AND TEACH REHABILITATION, A Manual by Mildred J. Allgire, RN, RPT, MA; the Springer Publishing Company, New York, 1968.

This paperback booklet describes the needs, values, procedures, and equipment needed for restoration of the disabled person so that he can make use of every ability that remains after illness or injury. It is the second edition, the publication of which was encouraged by the highly favorable acceptance of the first edition.

The fundamentals of care, effective for all age groups are covered, and the book points up the principles involved so that application may be found in almost any situation in the hospital or the home.

PHYSIOLOGY OF THE GASTROINTESTINAL TRACT, E. Clinton Texter, Jr., MD, Ching-Chung Chou, MD, Higino C. Laureta, MD, and Gaston R. VanTrappen, MD; The C. V. Mosby Company, St. Louis, 1968.

This is one in a series of coordinated texts dealing with body-system physiology, with which it is hoped there are some advantages. These books are oriented toward the medical student, their goal being to present current concepts of physiology.

In this present volume, the areas of physiological knowledge most relevant to medical practice are delineated. It is well-presented, and while directed toward the medical student, it would do no harm for the busy practitioner to read it and update himself in many ways.

CURRENT CONCEPTS IN ANESTHESIOLOGY, John Adriani, MD; The C. V. Mosby Co., St. Louis, 1968.

In recent years, anesthesiology has broadened its scope to encompass many subjects, such as the pharmacology of adjunctive anesthetic drugs, the hazards of drug interactions, and various phases of physiology, all of practical importance to the anesthesiologist.

These presentations are not exhaustive reviews that completely summarize all of the literature on a particular subject. They have been prepared by clinicians, written in clinicians' language and terminology, and intended primarily for clinicians.

(Continued next page)

TODD-SANFORD CLINICAL DIAGNOSIS BY LABORATORY METHODS, 14th ed., Israel Davidsohn, MD, and John Bernard Henry, MD; W. B. Saunders Co., Philadelphia, 1969.

The 14th edition of *Clinical Diagnosis by Laboratory Methods* aptly illustrates the advances which have taken place in the field of clinical pathology in the past 61 years. The first edition, written in 1906, by Dr. James C. Todd, *A Syllabus of Lectures Upon Clinical Diagnosis,* was only 124 pages and at the time, considered fairly complete and topical. The current text has expanded to 1,308 pages and is wanting in several areas. Gone is the era when the clinical pathologist was known as a physician technician —who worked from "a single kitchen table with a few shelves and a few bottles, screened off in a corner of the office, which sufficed for a laboratory."

The expanding field of clinical pathology has necessitated multiple contributors, in this case, 29 different experts from the fields of pathology, microbiology, clinical medicine, and laboratory medicine, to compile a text of this excellent stature.

The opening two chapters on the microscope and statistical tools in clinical pathology contain just enough highlights to be informational and to act as a backdrop for the remainder of the book. They are by no means meant to be complete in the areas that they cover. It would have seemed more logical to place the chapter on clinical chemistry (Chapter 10) next in sequence of the book because it is here that the basis of specimen collection and processing, mathematics, chemical calculations and basic laboratory techniques are discussed, which is basic to the remainder of the book.

The chapters which are best covered are those on blood, tests of hepatic function, serum enzyme deterioration, gastric and duodenal contents.

Examination of urine and renal function studies were well-done from the coverage of laboratory tests, but a bit brief as regards the application to clinical entities.

The sections on medical microbiology, protozoology, and mycology are excellent for rapid reference to simplified methods needed to accurately define the nature of common clinically encountered microorganisms.

The chapter on seminal and amniotic fluids are concise and well-written. Enough information is given for the clinical physician to apply the laboratory results of these areas with a minimal background of material.

In general, this book offers an excellent review for those physicians in clinical medicine who have a laboratory problem. It is a ready reference and presents an explanation of the laboratory studies and a brief review of the clinical possibilities. It is not a complete compendium or encyclopedia for any of the subjects covered. Anyone desiring more detailed information would have to refer to more complete textbooks on hematology, internal medicine, or endocrinology.

PAUL BORMEL, MD
Baltimore

A & F Nurses Registry



LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

Registered & Licensed

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.
BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

Help for the Alcoholic:
HIDDEN BROOK



Understanding care in an atmosphere conducive to Recovery

Request Brochure. Call 734-7554
Thomas Run Rd. Belair, Md. 21014

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization[1] — provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste — confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[2]

Concomitant relief of G. I. gas distress — provided by the proven antiflatulent action of simethicone[3].

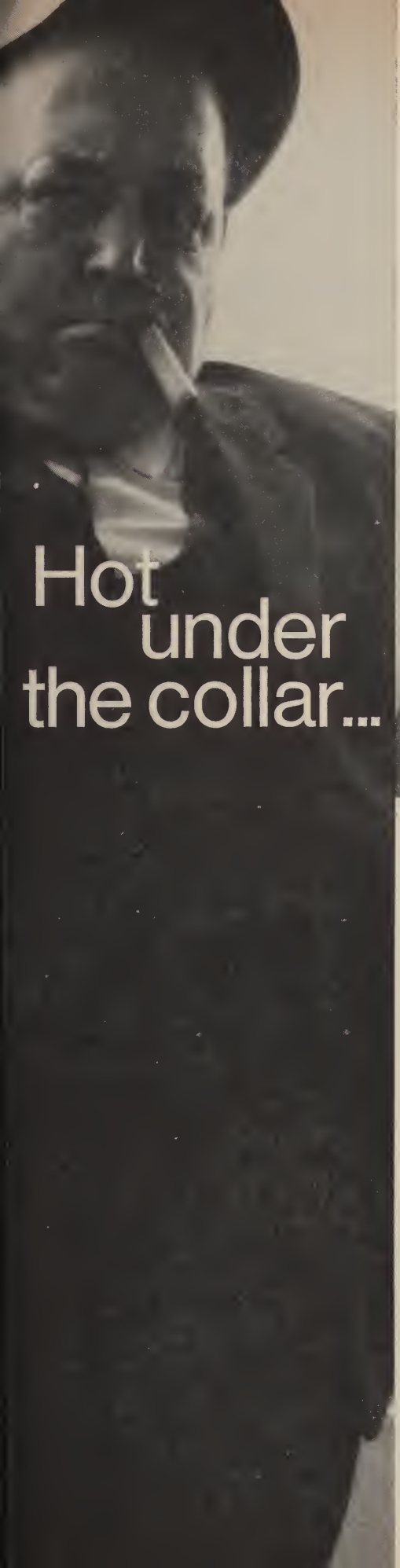
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonsful to be taken between meals and at bedtime, or as directed by physician.

References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey. (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109





Hot under the collar...



high under the cuff.

Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone	50 mg.
reserpine U.S.P.	0.25 mg.

To lower blood pressure
and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

vacation in
a vial:
the spasm
reactors
in your practice
deserve



"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
yoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
tropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
yoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
henobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.

(Warning: may be habit forming)

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

A·H·ROBINS

Two ways to provide your patients with a month's therapeutic supply of Vitamin C:



290 tangerines or 30 Allbee® with C.

Your patient would have to peel and eat 290 tangerines a month, almost 10 every day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.



A.H. Robins Company, Richmond, Va. 23220

BOARD OF MEDICAL EXAMINERS OF MARYLAND

1211 Cathedral Street

Baltimore, Maryland 21201

Addenda to Directory of Registered Physicians—Physicians Registered from July 31, 1968 to February 28, 1969

A

Adam, Baker H., MD, E. Texas T.B. Hospital, Box 2003, Tyler, Texas 75701
Adams, Elvin E., MD, 4723 Melbourne Rd., Baltimore, Md. 21204
Ahearn, Daniel J., MD, 11612 Lockwood Dr., Silver Spring, Md. 20904
Albert, Chalom A., MD, 4827 S. 8th St., Arlington, Va. 22204
Alfonso, Nicholas R., MD, 1811 5th St., S.E., Winter Haven, Fla. 33880
Altaker, Lawrence L., MD, 837 Azalea Dr., Rockville, Md. 20850
Alvarez, Reinaldo G., MD, Dix Haven Rd., Station A., Trenton, N.J. 08625
Amato, Joseph J., MD, Chief Clinical & Experimental Research, Biophysics Lab., U.S. Edgewood Arsenal, Edgewood, Md. 21010
Amin, Bipinchandra G., MD, 9185 Springhill Lane, Greenbelt, Md. 20072
Anderson, Daniel L., MD, 1808 Metzerott, Adelphi, Md. 20783
Anderson, Harry F., MD, 7900 Cypress Place, Chevy Chase, Md. 20015
Anderson, Irwin S., MD, 2530 Naylor Rd., S.E., Washington, D.C. 20020
Angov, George, MD, 5366 Carriage Ct., Baltimore, Md. 21229
Arnold, William Perry, MD, P.O. Box 36, Phoenix, Md. 21131
Arteaga, Lorgio F., MD, 445 Tremont St., N. Tonawanda, N.Y. 14120
Arthur, Arvin, MD, 7450 Chris Mar Ave., Clinton, Md. 20735

B

Bacmeister, Erwin, MD, 6403 Bellona Ave., Baltimore, Md. 21212
Bae, Chung K., MD, 113 F Rock Glen Rd., Baltimore, Md. 21229
Bailey, David W., MD, 14 Kentbury Way, Bethesda, Md. 20014
Balkissoon, Basdeo, MD, 1248 Monroe St., N.E., Washington, D.C. 20017
Barham, Ed D., MD, 9312 Piney Branch Rd., Silver Spring, Md. 20903
Bass, Frederic, MD, 6012 Wallis Ave., Baltimore, Md. 21215
Bass, Richard J., MD, 3009 Romaric Court, Baltimore, Md. 21209
Bauman, Roger A., MD, 14 W. Cold Spring Lane, Batlimore, Md. 21211
Beasley, J. Frank, MD, 828 E. Joppa Rd., Towson, Md. 21204
Belcher, Henry V., MD, U.S.P.H.S. Hospital, Baltimore, Md. 21211
Bellanca, Joseph J., MD, U.S. Naval Ordnance Lab., Whiteoak, Silver Spring, Md. 20910
Bellamy, Murlyn D., MD, 8 Bellclare Circle, Sparks, Md. 21152
Benacerraf, Baruj, MD, 4701 Willard Ave., Chevy Chase, Md. 20015
Bennett, Stephen H., MD, 550 N. Broadway, #100, Baltimore, Md. 21205
Bennion, Jerald H., MD, 508 E. South Temple, Salt Lake City, Utah 84102
Benzinger, Maria, MD, 6607 Broxburn Drive, Bethesda, Md. 20034
Berman, Martin M., MD, 6309 Winner Ave., Baltimore, Md. 21215
Biles, James D., III, MD, 1522 Medford Rd., Baltimore, Md. 21218
Billingsley, Frank S., MD, 8416 Westmont Terr., Bethesda, Md. 20034
Birebaum, Georges, MD, 1807 Woodbourne Ave., Baltimore, Md. 21214
Bird, Dan C., MD, 5120 Parklawn Terr., Apt. 204, Rockville, Md. 20852
Birnholz, Jason C., MD, 10500 Rockville Pike, Rockville, Md. 20852
Blackburn, Frank C., MD, 1 Jasmine Court, Rockville, Md. 20853
Blaustein, Arnold S., MD, 6664D Reider Ct., P.O. Box 936, Edgewood, Md. 21040
Bluemle, Lewis W., Jr., MD, Clinical Research Center, Hospital of the University of Pennsylvania, 3400 Spruce St., Philadelphia, Pa. 19104
Bluestein, Harry G., MD, 10201 Grosvenor Pl., Rockville, Md. 20852
Boone, Owen R., MD, 6500 Hampton Blvd., Norfolk, Va. 23508
Boudreaux, Veltin J., Jr., MD, P.O. Box 104, Edgewood Arsenal, Md. 21010
Bowers, Mirion P., MD, 1415 Peaceful Lane, Silver Spring, Md. 20904
Bowling, Chetwynd E., MD, Apt. 303, 1415 Southern Ave., Oxon Hill, Md. 20032
Bradshaw, Mary E., MD, 3337 Claridge Ct., Wheaton, Md., 20902
Bradshaw, Walter H., Jr., MD, 3337 Claridge Ct., Wheaton, Md. 20902
Brancato, Donald H., MD, 5723 Harford Rd., Baltimore, MD, 21214
Bravo, Anthony J, MD, 766 College Pkwy., Rockville, Md. 20850
Bretz, Giselle T., MD, 550 N. Broadway, Baltimore, Md. 21205
Brown, Merrilyn L. S., MD, 1 University Pkwy, East, Baltimore, Md. 21218
Brown, Robert J., III, MD, 13113 Cabinwood Dr., Silver Spring, Md. 20904
Brusca, Peter A., MD, 25 Officers' Court, Lexington Park, Md. 20853
Bruther, Lawrence J., MD, 5055 Seminary Rd., Apt. 1634, Alexandria, Va. 22311
Buch, Antonio L., MD, 550 Forest Ave., Buffalo, N.Y. 14222
Bunai, Russell J., Jr., MD, 8803 Maxwell Drive, Potomac, Md. 20854
Burrows, Benjamin, MD, 350 Sierra Vista Dr., Tucson, Arizona 85719
Butler, Alan R., MD, 4312 Fernhill Avenue, Baltimore, Md. 21215
Butterfield, James B., MD, 13001 Crookston Lane, Apt. 15, Rockville, Md. 20851

C

Cabrera, Juan J., MD, 2628 Lynhaven Ave., Apt. N., Richmond, Va. 23234
Calhoun, Thomas J., MD, 57A "G" St., S.W., Washington, D.C. 20024
Callison, James R., MD, 500 Halstead Johns Hopkins Hospital, Baltimore, Md. 21205
Campbell, Alice P., MD, 4144 Suitland Rd., #301, Suitland, Md. 20023
Canter, Jane M., MD, 1404 Hampshire West Court, Apt. 13, Silver Spring, Md. 20903
Carreno, Jose A., MD, V.A. Center, P.O. Box 756, Wadsworth, Kansas 66089
Carter, Charles B., MD, 10877 Bucknell Drive, Wheaton, Md. 20902
Carter, Stephen K., MD, 5200 Crossfield Ct., Rockville, Md. 20852
Casler, Travis L., MD, 550 N. Broadway, Apt. 1109, Baltimore, Md. 21205
Cassady, James R., MD, 7822 Custer Rd., Bethesda, Md. 20014
Castadot, Robert G., MD, 6114 Marlora Rd., Baltimore, Md. 21212
Castillo, Juan F., MD, 325 29th St., Union City, N.J. 07087
Catalano, Kathleen F., MD, 4977 Battery Lane, #113, Bethesda, Md. 20014
Caussade, Jose J., MD, 1125 Avenue C., Perry Point, Md. 21902
Cauthorne, Robert T., MD, Division of Gastroenterology, Dept. of Med., Johns Hopkins Hospital, Baltimore, Md. 21205
Certeza, Humberto V., MD, 5704 Leith Walk, Baltimore, Md. 21212
Chamberlain, Phil M., MD, 1801 Clydesdale Pl., N.W., Washington, D.C. 20009
Chang, Poo Liang, MD, 1401 Blair Mill Road, Silver Spring, Md. 20910
Chavez, Juan M., MD, 3223 Avon Ave., Baltimore, Md. 21218
Cheng, Gabriel K. C., MD, 150 S. Huntington Ave., Boston, Mass. 02130
Cheng, Viola, W. C., MD, 1401 Blair Mill Rd., Silver Spring, Md. 20910
Chilimindris, Constantinos P., MD, 3006 Abell Ave., Baltimore, Md. 21218
Chisholm, Cecilin L., MD, 1414 Upshur St., N.W., Washington, D.C. 20011
Chisholm, Joseph C., Jr., MD, 9514 Caroline Ave., Silver Spring, Md. 20910
Chura, Catherine M., MD, 7710 Maple Ave., Takoma Park, Md. 20012
Cilliani, Ines S., MD, 6104 E. Pratt St., Baltimore, Md. 21224
Cinca, Eduardo E., MD, 1600 South Ave., Rochester, N.Y. 14620
Cohen, Elliot S., MD, 2260 Liliha St., Honolulu, Hawaii 96817
Cohen, Ora Richard, MD, 7520 Maple Ave., Takoma Park, Md. 20012
Collado, Raimundo A., MD, Eastern Shore State Hospital, Cambridge, Md. 21613
Cohen, Adrian M., MD, 94 Ginwood Lane, Baltimore, Md. 21221
Conn, Rex B., Jr., MD, 10087-B Windstream Dr., Columbia, Md. 21043
Conrad, Harold T., MD, 5454 Wisconsin Ave., Chevy Chase, Md. 20203
Cooper, James N., MD, 7887 Patriot Dr., Annandale, Va. 22003
Cooper, Theodore, MD, 6711 Greyswood Rd., Bethesda, Md. 20034
Couch, James R., Jr., MD, 6108 23rd Pkwy., Oxon Hill, Md. 20031
Cromwell, David K., MD, 7730 Maple Ave., Apt. 20, Takoma Park, Md. 20012
Crummy, Charles S., MD, 5515 Alta Vista Rd., Bethesda, Md. 20014
Cuevas, Corazon M., MD, 1300 Denby Rd., Hampton Gardens, Towson, Md. 21204
Culp, Clifford L., Jr., MD, 710 Carr Ave., Rockville, Md. 20850
Culton, John W., MD, 103 Enchanted Hills Rd., Apt. 202, Owings Mills, Md. 21112
Custis, Horace H., Jr., MD, 1852 Columbia Rd., N.W., Washington, D.C. 20009

D

Dachman, Monis, M., MD, 4410 16th St., N.W., Washington, D.C. 20011
Daniel, Joseph, MD, 121 North 5th Ave., Coatesville, Pa.
Daniels, William D., MD, 3321 Glenway Drive, Kensington, Md. 20975
Daniels, Willie L., MD, 631 Liberty St., El Cerrito, Calif. 94530
Das, Chander P., MD, 1624 Oakland Pkwy., Lima, Ohio 45805
Daugela, Stasys B., MD, 2316 Tunlaw Rd., N.W., Washington, D.C. 20007
Davis, James K., MD, 101 E. Mt. Royal Ave., #758, Baltimore, Md. 21201
Davis, William R., MD, 5304 Rayburn Place, Camp Springs, Md. 20031
Daw, Albert L., MD, 6415 Cedar Lane, Temple Hills, Md. 20031
Day, William K., MD, Sheppard-Pratt Hospital, Towson, Md. 21204
Define, Fidelis C. D., MD, Town & Country Apts., W., 8A W. Springs Drive, Ellicott City, Md.
Dehner, Louis P., MD, 4328 Montgomery Avenue, Bethesda, Md. 20014
Del Castillo, Demetrio A. A., MD, 1101 S.W. 4th St., Apt. #1, Miami, Fla. 33130
Denefield, Beatrice A., MD, 5611 Lothian Rd., Baltimore, Md. 21212
DeSanctis, Alfred L., MD, 845 8th St., N.E., Massillon, Ohio 44646
Devenis, Algirdas, M., MD, 505 Lakeview Ave., Milford, Del. 19963
DeZayas, Luis P., MD, 5410 Knob Rd., Nashville, Tenn. 37209
DiBiasio, Armando G., MD, 7803 Ful-Bright Ct., Bethesda, Md. 20034
Dixon, Cecil B., MD, 1309 Friend St., S. Boston, Va. 24592
Dluhy, John M., Jr., MD, 5909 Cherrywood Terr., Greenbelt, Md. 20770
Dobbins, Richard F., MD, 5517 Lincoln St., Bethesda, Md. 20034
Dodson, William E., MD, 4717 N. Chelsea Lane, Bethesda, Md. 20014
Donayre, Luis E., MD, 232 Hawthorne Rd., Elkin, N. Carolina 28621
Dorr, David C., MD, 3808 32nd St., Mt. Rainier, Md. 20822
Dovi, Sebastian F., Jr., MD, 14503 Bauer Dr., Rockville, Md. 20853
Downs, Sidney L., MD, 108 Bard Ave., Apt. #2, Staten Island, N.Y. 10310
Drake, Frank R., Jr., MD, 9316 Cherry Hill Rd., #102, College Park, Md. 20740
Durfey, John Q., MD, Office of Aviation Medicine, Federal Aviation Adm., 800 Independence Ave., S.W., Washington, D.C. 20590
DuPont, Herbert L., MD, 1946 Winder Rd., Baltimore, Md. 21207
Duvall, Victor F., MD, 31 Vista Mobile Dr., Baltimore, Md. 21222

E

Earles, Rene M., 2300 Goodhope Rd., S.E., Washington, D.C. 20020
Ehrlich, Bernard, MD, 1111 Spring St., Silver Spring, Md. 20910
Ellis, William, MD, Box 3317, Duke Hospital, Durham, N.C.
Erim, Zeki, MD, 7840 Doane Ct., Springfield, Va. 22150
Evans, Charles M., MD, 69 Officer's Ct., Lexington Park, Md. 20653
Evarts, Edward V., MD, 8600 Beach Tree Rd., Bethesda, Md. 20034

F

Fairbanks, Grant R., MD, 4852 Melbourne Rd., Baltimore, Md. 21229
Farahmand, Firouz, MD, Parma Hghts., Ohio 44130
Fatles, Constantine T., MD, 5088 Silver Hill Ct., Suitland, Md. 20028
Feijoo, Julio A., MD, 2306 William St., Petersburg, Va. 23803
Feinleib, Manning, MD, 11028 Seven Hill Lane, Potomac, Md. 20854
Fernandez-Lopez, Ulpiano, MD, State Hospital, Clarks Summit, Pa. 18411
Fidler, Stuart M., MD, 6824 Walker Mill Rd., Apt. #302, District Hghts., Md. 20027
Finkelstein, Daniel, MD, 5821 Johnson Ave., Bethesda, Md. 20014
Fitzgerald, Geoffrey, MD, 6 Jackson Dr., Setauket, N.Y. 11785
Fletcher, Anne B., MD, 4807 Arctic Ct., Rockville, Md. 20853
Fogel, Lawrence J., MD, 225 Lakeside Dr., Greenbelt, Md. 20770
Font, Ramon L., MD, 700 Hermleigh Rd., Silver Spring, Md. 20902
Foote, Leonard H. B., MD, 1747 S. Adams St., Tallahassee, Fla. 32301
Fratantoni, Joseph C., MD, 11911 Parklawn Dr., Rockville, Md. 20852
Freebern, Robert Kenneth, MD, 21 Sussex Rd., Silver Spring, Md. 20910
Fulk, Billy R., MD, 1501 Bay Bridge Ave., Annapolis, Md. 21402
Fulton, Edwin C., MD, 2223 H St., N.W., Apt. 708, Washington, D.C. 20037

G

Gamble, Henry F., III, MD, 5906 Cherrywood Terrace, Apt. 304, Greenbelt, Md. 20770
Gambrill, Raymond, III, MD, 923 Elmridge Ave., Baltimore, Md. 21229
Gans, Jack S., MD, 4 Agawam Lane, Huntington, N.Y. 11743
Garcia, Joaquin R., MD, 1126 Ave. C., Perry Point, Md. 21902
Garcia, Leoncio A., MD, 102 Laurel Circle, Charlottesville, Va. 22903
Garcia-Ferrer, Eduardo A., MD, 2275 Crandell Dr., St. Louis, Mo. 63136
Gaudry, Charles L., Jr., MD, 5502 Burling Ct., Bethesda, Md. 20034
Gayle-Thompson, Delores J., MD, 2039 Blackrock Ave., Apt. 4-H, Bronx, N.Y. 10473
Gelderman, Albert H., MD, 6705 Barr Rd., Bethesda, Md. 20016
Gelpi, Jose A., MD, 1130 Baker Ave., Baltimore, Md. 21207
Gering, Henry S., MD, 8003 Carey Branch Dr., Oxon Hill, Md. 20022
Gillilan, Ronald E., MD, 222 Wight Ave., Cockeysville, Md. 21030
Ginter, Donald N., MD, 8 Lyric Ct., Towson, Md. 21204
Gokulanathan, Karakat S., MD, 2125 13th St., N.W., Wash., D.C. 20009
Gold, Lawrence W., MD, 8422 10th Ave., Silver Spring, Md. 20903
Goldman David M., MD, 9340 Edmonston Rd., Greenbelt, Md. 20770
Gongon, Manuel A., MD, 5303-C Moravia Rd., Baltimore, Md. 21206
Gorman, Patrick A., MD, 7210 Churchill Rd., McLean, Va. 22101
Gorsuch, George E., MD, Naval Hospital, Bethesda, Md.
Gotto, Antonio M., Jr., MD, 11915 Parklawn Dr., Rockville, Md. 20852
Graham, William H., MD, 10505 Lorain Ave., Silver Spring, Md. 20901
Granett, Jeffrey R., MD, 436 E. 69th St., New York, N.Y. 10021
Granoff, Dan M., MD, Hopkinson House, Washington Sq., S., Philadelphia, Pa. 19106
Graves, David B., MD, 11006 Tyrone Dr., Upper Marlboro, Md. 20870
Greeen, Ira, MD, 6207 Hollins Drive, Bethesda, Md. 20034
Greenberg, Arnold H., MD, 102-2205 Rogene Dr., Baltimore, Md. 21209
Greenough, William B., III, MD, 1110 Bellemore Rd., Baltimore, Md. 21210
Groban, Mark D., MD, 2032 Georgian Woods Pl., Wheaton, Md. 20902
Grumberg, Iosef, MD, 4911 Poe Ave., Baltimore, Md. 21215
Guttmann, Gad G., MD, 730 24th St., N.W., Washington, D.C. 20037
Gwozdz, Nicholas E., MD, 7620 Carteret Rd., Bethesda, Md. 20034

H

Hagenbucher, John T., MD, 4704 Merivale Rd., Chevy Chase, Md.
Hall, Macy G., Jr., MD, 1336 Missouri Ave., N.W., #507, Washington, D.C. 20011
Halmos, Peter B., MD, 302 Schley St., Cumberland, Md. 21502
Hambrecht, Frederick T., MD, 137 Park Lane Dr., Galesburg, Ill. 61401
Hamby, James L., MD, University of Md. Hospital, Baltimore, Md.
Hammermeister, Karl E., MD, 15 Warren Lodge Ct., Apt. C, Cockeysville, Md. 21030
Hanashiro, Paul K., MD, 8203 Thornton Rd., Baltimore, Md. 21204
Hano, Jessie E., MD, 8905 Kimes St., Silver Spring, Md. 20901
Hansen, Herman R., MD, 1317 Dogwood St., N.W., Washington, D.C. 20012
Harris, Robert H., Jr., MD, 4 Strauss Ave., Indian Head, Md. 20640
Heitzman, Sister Celine I. C., MD, 4514 Lyons Ave., Houston, Texas 77020
Henneberger, George Milton, MD, 404 Lakeview Ave., Milford, Del. 19963
Heredia, Miguel A., MD, 5442 Jamestowne Ct., Baltimore, Md. 21229
Hernandez, Carlos M., MD, Rt. #1, Box 217, Raiford, Fla. 32083
Heyssel, Robert M., MD, 604 Edgevale Rd., Baltimore, Md. 21210
Hicks, Russell D., MD, 6008 E. Pratt St., Baltimore, Md. 21224
Hiehle, Wilbur W., MD, 4322 O'Kane Ct., Ft. George G. Meade, MD. 20755
Hill, Constance H., MD, 276 Meeker Ave., Newark N.J. 07112
Hill, Eleanore M., MD, 10630 Montrose Ave., Bethesda, Md. 20014
Hirsh, Harold L., MD, 2801 N. Mexico Ave., N.W., Apt. 609, Washington, D.C. 20007
Hoffman, Paul M., MD, 3910 Bel Pre Rd., Apt. 4, Silver Spring, Md. 20906
Hooper, Stephen Leroy, MD, 303-1 Queensdale Dr., York, Pa. 17403
Horman, Marc J., MD, 630 Azalea Drive, Rockville, Md. 20850
Huffman, David H., MD, 550 N. Broadway, Baltimore, Md. 21205
Hurm, Mark S., MD, Box 112, RD 3, Elkton, Md.
Hurwitz, Edward J., MD, 800 Fourth St., S.W., Apt. N312, Wash., D.C. 20024
Huse, Robert D., MD, 2413 Harwood Rd., Baltimore, Md. 21234

I

Iranyi, Magdolna A., MD, 3541 W. Braddock Rd., Alexandria, Va. 22302
Israel, Charles W., MD, 11501 Colt Terrace, Silver Spring, Md. 20902
Itscoitz, Samuel B., MD, 4720 Chevy Chase Dr., #103, Bethesda, Md. 20015

J

Jackson, Marvin A., MD, 1428 Iris St., N.W., Washington, D.C. 20012
Jacobs, Robert E., MD, 2301 "E" St., N.W., Washington, D.C. 20037
Jaslow, Robert I., MD, 6037 Rossmore Drive, Bethesda, Md. 20014
Jean-Jacques, Anthony, MD, 3332 Chauncey Pl., Apt. 102, Mt. Rainier, Md. 20822
Jeffries, Mervyn, MD, 6224 Goodview St., Bethesda, Md. 20034
Jimenez, Jesus G., MD, 8833 Canfield Ct., Alexandria, Va. 22308
Jimenez, Raul A., MD, Springfield St. Hospital, Sykesville, Md. 21784
Johnson, Walter T., MD, 14134 Flint Rock Rd., Rockville, Md. 20853
Jones, William P., MD, U.S. Naval Hospital, San Diego, Calif. 92134

K

Kabo, Robert D., MD, 503 Brightwood Rd., Millersville, Md. 21108
Kaiser, Irwin H., MD, Bronx Municipal Hospital Center, Room 709 Jacobia, Bronx, N.Y. 10461
Kalin, Joshua, MD, 523 Capitol Trail, Newark, Delaware 19711
Kappy, Michael S., MD, 13015 St. Charles Pl., Rockville, Md. 20853
Karlsberg, Robert C., MD, Johns Hopkins Hospital, Baltimore, Md. 21205
Katon, Richard N., MD, 3013 Romaric Court, Baltimore, Md. 21209
Katz, Robert, MD, 20 Volturno St., Ft. Bragg, N. Carolina 28307
Kaufmann, Reto W., MD, 815 S. 18th St., Arlington, Va. 22202
Kelly, Alex R., MD, 5909 Searl Terr., Bethesda, Md. 20016
Kenworthy, Richard A., III, MD, 15015 Parthenia St., Sepulveda, Calif. 91343
Khayat, Azeez V., MD, 4451 Springdale St., N.W., Washington, D.C. 20016
Khoury, Assad S., MD, Washington Clinic—3401 Western Ave., N.W., Washington, D.C. 20015
Kibelstis, John A., MD, 8716 Wendell Avenue, M.D., Parkville, Md. 21234
Killinger, Robert P., MD, 4 Taney Ave., Annapolis, Md. 21401
Kilpe, Vilis E., MD, 1010 E. Belvedere Ave., Baltimore, Md. 21212
Kim, Hack J., MD, 2409 W. Garrison Ave., Baltimore, Md. 21215
Kleinerman, Morris, MD, 7207 Rollingwood Dr., Chevy Chase, Md. 20015
Kling, Robert P., MD, 600 Hillwood Ave., Falls Church, Va. 22042
Klingenmaier, Charles H., MD, 2501 Fauquier Lane, Reston, Va. 20070
Kluge, Ronica M., MD, 2827 N. Calvert St., Baltimore, Md. 21218
Koh, Dae S., MD, 13909 Rippling Brook Dr., Wheaton, Md. 20902
Kohler, Peter O., MD, 7712 Dew Wood Dr., Rockville, Md. 20855
Korbuly, Domokos E., MD, 286 Bloomsbury Ave., Baltimore, Md. 21228
Koryak, Ozker T., MD, P.O. Box 234, Crownsville, Md. 21032
Krickovic, Milan P., MD, 3425 Janvale Rd., Baltimore, Md. 21207
Kroe, Donald J., MD, Medical Research Laboratories, Edgewood Arsenal, Md. 21010
Kwas, Stephen K., MD, 750 Azalea Dr., Rockville, Md. 20850

L

LaBosco, Louis A., MD, USAD (A2111-02) Ft. Holabird, Baltimore, Md. 21219
Labrit, Alfredo, MD, Springfield State Hospital, Sykesville, Md. 21784
Lacey, Wilbert, MD, 4013 Meade St., N.E., Washington, D.C. 20019
Lagoc, Araceli T., MD, 3400 Alabama Ave., S.E., Washington, D.C. 20020
Lane, Stanley R., MD, 6202 Springhill Dr., Greenbelt, Md. 20770
Langebeck, Miguel, MD, 1835 I St., N.W. 808, Washington, D.C. 20006
Lapeyra, Joseph J., MD, 38-33 222 St., Bayside, N.Y. 11361
LaPiana, Francis G., MD, 10310 Calumet Dr., Silver Spring, Md.
Larimer, Alan McC., MD, 56 Cornhill St., Annapolis, Md. 21401
Lawrence, James, III, MD, 34 Olmsted Green, Baltimore, Md. 21210
Lawson, Noel S., MD, Med. Res. Lab., Edgewood Arsenal, Md. 21010
Lechner, Benjamin L., MD, 5910 E. Pratt St., Baltimore, Md.
Lerner, William D., MD, 1203 St. Paul St., Baltimore, Md. 21201
Lessin, David E., MD, Georgia Bldg.—Warwick Apts., Aberdeen, Md. 21005
Levey, Barbara A.C., MD, 271 Congressional Lane, Rockville, Md. 20852
Levey, Gerald S., MD, 271 Congressional Lane, Rockville, Md. 20852
Levi, Joe U., MD, 550 N. Broadway, Apt. 700, Baltimore, Md. 21205
Levi, L. David, MD, Grosvenor Park, 10500 Rockville Pike, Apt. 211, Rockville, Md. 20852
Levin, Harold A., MD, 123 Willow Ave., Towson, Md. 21204
Levine, Seymour, MD, 1620 McElderry St., Baltimore, Md. 21205
Levinsohn, Eugene M., MD, 6116 E. Pratt St., Baltimore, Md. 21224
Lewis, John N., MD, 274-5 Schucht Village, Gainesville, Fla. 32601
Lichtmann, Albert L., MD, 6304 Long Meadow Rd., McLean, Va. 22101
Lipman, Frances J., MD, 8508 16th St., #521, Silver Spring, Md. 20910
Llaneras, Rene F., MD, 1400 S. Barton St., #408, Arlington Co., Va. 22204
Long, Jack C.S., MD, Box 197, Univ. Texas Medical Branch, Galveston, Texas 77550
Lopez-Marino, Jose, MD, V.A. Center, P.O. Box 207, Wadsworth, Kansas 66089
Lorenzo, Ciriaco Morales, MD, 8102 15th Avenue, #1, Hyattsville, Md. 20783
Lowe, Thomas F., MD, 6040 Richmand Hghwy., Belle Haven Towers #409, Alexandria, Va. 22309
Lowen, Marc, MD, 3009 Romaric Ct., Baltimore, Md. 21209
Luchsinger, Peter C., MD, 2800 Wisconsin Ave., N.W., Washington, D.C. 20007
Ludlum, David Blodgett, MD, Dept. of Pharmacology, Univ. of Maryland, Baltimore, Md. 21201
Lulejian, Gary A., MD, Briarcliff Village, 10305-C Malcolm Circle, Cockeysville, Md. 21030

Mc

McAllister, Clyde H., MD, 1429 Coal St., Pittsburgh, Pa. 15221
McCloskey, Keith R., MD, 1116 Sherwood Ave., Baltimore, Md. 21212
McCormack, Hugh B., MD, 13604 Dowlais Dr., Rockville, Md. 20853
McDaniel, Ellen G., MD, 602 Bridgeman Terr., Towson, Md. 21204
McLaren, Ian D., MD, 13611 Russett Terrace, Rockville, Md. 20853

McLeod, David G., MD, 10025 Renfrew Rd., Silver Spring, Md. 20901
McNamara, William A., MD, 9928 Brixton Lane, Bethesda, Md. 20034
McNinch, Eugene R., Jr., MD, 601 Indiana St., Johnstown, Pa. 15905

M

Machledt, John H., Jr., MD, 6 Sells Ave., Apt. C, Columbus, Ohio 43212
Magovern, Malcolm J., Jr., MD, 900 N. Broadway, Saratoga Springs, N.Y. 12866
Magre, Joseph P., MD, 29 Hemlock Dr., Lock Haven, Pa. 17745
Malloy, John P., MD, 14100 Arctic Ave., Rockville, Md.
Maltz, David L., MD, 12 Kilsyth Terrace, Brighton, Mass. D2146
Mandel, Lloyd B., MD, 6228G Laurelton Ave., Baltimore, Md. 21214
Mandeville, Edgar O., MD, 29-18 Butler St., E. Elmhurst, N.Y. 11369
Mangi, Richard J., MD, 13 Kenlawn Ct., Towson, Md. 212D4
Maoury, Stanley D., MD, 150 Impalla Dr., Manassas, Va. 22110
Marcus, Robert L., MD, 3807 Juniper Rd., Baltimore, Md. 21218
Mardiney, Michael R., Jr., MD, 7818 Ruxway Rd., Baltimore, Md. 21204
Martinez, Guillermo, MD, Lima State Hospital, Lima, Ohio 45802
Martinez-Colon, Elba J., MD, 2107 Walsh View Terr., Silver Spring, Md. 20902
Marx, Stephen J., MD, 6 Whittier Pl., Boston, Mass. 02114
Mashburn, Joseph D., MD, Laboratory, Washington Sanitarium & Hospital, Takoma Park, Md.
Mastrangelo, Giovanni, MD, 227 Cecelia St., Cumberland, Md. 21502
Matthey, Carl Henry, Jr., MD, 12515 Fair Crest, S.W., Portland, Ore. 97225
May, Robert D., MD, #506—6011 Emerson St., Bladensburg, Md. 20710
Mayman, David, MD, 550 N. Broadway, #908, Baltimore, Md. 21205
Mayson, Preston B., Jr., MD, 14115 Arctic Ave., Rockville, Md. 20853
Mellin, Harold, MD, 2243 Rogene Dr., Baltimore, Md. 21209
Melman, Arnold, MD, 27 Thornhurst Ct., Baltimore, MD, 21207
Mencher, Edward W., MD, 501 S. Union Ave., Havre de Grace, Md. 21D78
Merritt, Thomas B., MD, 4802 Flanders Ave., Kensington, Md. 20795
Meyer, Walter J., III, MD, 2829 S. 8th St., Minneapolis, Minn. 55406
Michels, Ronald G., MD, 550 N. Broadway, #303, Baltimore, Md. 21205
Miller, Edward J., MD, 9304 Milroy Pl., Bethesda, Md. 20014
Miller, Edwin C., MD, 506 Park Ave., Portage, Pa.
Miller, Laurence H., MD, 10901 Amherst Ave., Silver Spring, Md. 20902
Miller, Stephen W., MD, 5910 Rolston Rd., Bethesda, Md. 20034
Mills, John, MD, 5801 Wilson Lane, Bethesda, Md. 20034
Minnefor, Anthony B., MD, 10309 Malcolm Circle, Apt. H., Cockeysville, Maryland
Mirowski, Mieczyslaw, MD, 3824 Menlo Drive, Baltimore, Md. 21215
Mitchell, Donna L. J., MD, 18D E. Delaware Pl., Chicago, Ill. 60611
Mitchell, Keiffer J., MD, 201D Hillenwood Rd., Baltimore, Md. 21214
Mitchell, Percy D., MD, 180 E. Delaware Pl., Apt. 5H, Chicago, Ill. 60611
Monakil, Dante U., MD, 212 Washburn Dr., E. Syracuse, N.Y. 13057
Moore, James R., Jr., MD, 11510 Maple View Dr., Wheaton, Md. 20902
Montakhab, Hamid, MD, 182D Metzerott Rd., #35, Adelphi, Md. 20783
Morales, George A., MD, 10300 Chapel Rd., Potomac, Md. 20854
Morowitz, David A., MD, 9237 Three Oaks Dr., Silver Spring, Md. 20901
Moss, Gene R., MD, 2924 Wilton Ave., Silver Spring, Md. 20910
Mostaan, Reza, MD, 11200 Lockwood Dr., #81D, Silver Spring, Md. 20901
Moutsos, Spero E., MD, 359 McKee Place, Pittsburgh, Pa. 15213
Muellner, Robert L., MD, 9120 Hempstead Ave., Bethesda, Md. 20034
Mullins, Charles E., MD, 4612 Bel-Pre Rd., Rockville, Md. 20853
Muroff, Lawrence R., MD, 12000 Old Georgetown Rd., Apt. C-1104, Rockville, Md. 20852
Murphy, Dennis L., MD, 5424 Alta Vista Rd., Bethesda, Md. 20014
Murphy, John C., MD, 3670 Hilmar Rd., Baltimore, Md. 212D7
Museles, Melvin, MD, 14905 Waterway Drive, Rockville, Md. 20853
Mutty, Lawrence B., MD, 1620 McElderry St., Apt. 12C2, Baltimore, Md. 21205
Myron, Paul V., MD, 7207 Radnor Rd., Bethesda, Md. 20034

N

Nadler, Joel B., MD, 3412 Toledo Terr., Apt. G-1, Hyattsville, Md. 2D783
Nagy, Stephen M., Jr., MD, 6146 E. Pratt St., Baltimore, Md. 21224
Namrow, Arnold, MD, 4501 Connecticut Ave., N.W., Washington, D.C. 20008
Nelson, Fred R. T., MD, 5618 Ogden Rd., Bethesda, Md. 20016
Neumaier, George J., MD, 44 Officers Ct., Lexington Park, Md. 20653
Neumaster, Terry D., MD, 14002 Cove Lane, Apt. 303, Rockville, Md. 20853
Nodal, Guido F., MD, 1218 N. 60th Street, Waco, Texas 76710
Nothwanger, Robert C., MD, 400 Pershing Dr., Silver Spring, Md. 20910

O

Ocejo, Gladys A., MD, 1147 B Ave., Perry Pt., Md. 21902
O'Malley, Bert Wm., MD, 5403 Parkvale Terr., Rockville, Md. 20853
Oppenheimer, Stuart, MD, 3309 Retlaw Rd., Baltimore, Md. 21207
Orlando, Joseph C., MD, 3018 Orlando Ave., Baltimore, Md. 21234
Orringer, Mark B., MD, 550 N. Broadway, Baltimore, Md. 21205
Otter, Thomas A., MD, 550 N. Broadway, Baltimore, Md. 21205
Ozkok, Fikret, MD, Hospital Station, Crownsville, Md. 21032

P

Pabla, Gursewa S., MD, 7027 "A" St., Seat Pleasant, Md. 20027
Pachuta, Donald M., MD, 103-A S. Charter Rd., Glen Burnie, Md. 21061
Paige, David M., MD, 3809 Menlo Dr., Baltimore, Md. 21215
Palumbo, Pasquale M., Jr., MD, 3910 King Arthur Rd., Annandale, Va.
Pande, Shashi K., MD, 610 Colorado Ave., Baltimore, Md. 21210
Pantuck, Eugene J., MD, 5921 Western Run Dr., Baltimore, Md. 21209
Parker, Jeff, MD, 4633 Marble Hall Rd., Baltimore, Md. 21212
Patterson, Robert D., MD, 9609 Carriage Road, Kensington, Md. 20795
Paulino, Adoracion De B., MD, 6811 Barnett Rd., Baltimore, Md. 21212
Peele, Roger, MD, 5512 Joyce Dr., Camp Springs, Md. 20031
Penaranda, Delza L., MD, 48 Michael Dr., Henrietta, New York 14467
Penichet, Rafael J., MD, 1730 Windover Rd., Apt. 11, Columbia, S.C. 29204
Perez-Balboa, Juan A., MD, P.O. Box 22, Spring Grove State Hospital, Baltimore, Md. 21228
Perez-Colon, Julio J., MD, 3411 Carlyn Spring Rd., Apt. T-3, Falls Church, Va. 22041
Perez-Sanz, Bautista, MD, 134 Church St., Apt. 8-2C, Kings Park, N.Y. 11754
Perry, Richard B., MD, 8220 Cindy Lane, Bethesda, Md. 20034
Perryman, William T., Jr., MD, 4110 Blackpool Rd., Rockville, Md. 20853
Peters, George N., MD, 1557 E. Monument St., Baltimore, Md. 21205
Petri, Edward J., MD, 5604 Claridge Rd., Camp Springs, Md. 20031
Pfeffer, William H., MD, 815 S. Georgia St., York, Pa. 174D3
Phillips, Cosmos B., MD, 122 Ashland Pl., #7N, Brooklyn, N.Y. 11201
Pierce, Nathaniel F., MD, 82D E. Joppa Rd., Towson, Md. 21204
Plecharty, George P., MD, 3500 Park Ave., Weehawken, N.J. 07087
Pollock, Edward J., MD, 7505 Democracy Blvd., Bethesda, Md. 20034
Pooya, Manoochehr, MD, 6319 Landover Rd., #204, Cheverly, Md. 20785
Pope, Henry, MD, 105 2nd Street, Laurel, M.D.
Port, David Marshall, MD, 5500 Prospect St., Apt. North 2022, Chevy Chase, Md. 20015
Posner, Carol J., MD, 29 Dowling Circle, Apt. B, Baltimore, Md. 21234
Powell, James O., MD, P.O. Box 878, Edgewood, Md. 21040
Powers, William E., Jr., MD, 6010 E. Pratt St., Baltimore, Md. 21224
Pressman, Barry D., MD, 1909 Parklawn Dr., Rockville, Md. 20852
Pretell, Ana M., MD, 9403 Curran Rd., Silver Spring, Md. 20901
Pyeatte, Joella C., MD, 26 Bouton Green, Baltimore, Md. 21210

R

Rafi, Esmail, MD, 6219 Crestwood Dr., Alexandria, Va. 22312
Ramirez, Carlos F., MD, 14 Wesley Pl., Tuscaloosa, Ala. 35401
Reading, Anthony J., MD, 21 Acorn Circle, Baltimore, Md. 21204
Reece, William W., MD, St. Elizabeth's Hospital, Washington, D.C. 20032
Rees, Thomas R., MD, 4715 32nd St., N.W., Washington, D.C. 20008
Reiskin, Joel A., MD, 10500 Rockville Pike, Apt. 1025, Rockville, Md. 20852
Reiss, David, MD, 5503 Northfield Rd., Bethesda, Md. 20034
Rigaud, Marie C. St.J., MD, 3908 Ferndale Ave., Baltimore, Md. 21207
Righini, Massimo A., MD, 1921 Biltmore St., N.W., Washington, D.C. 20009
Rimish, Rorick T., MD, 720 Milton Rd., Rye, N.Y.
Rivat, Ella L., MD, 3726 Connecticut Ave., N.W., Washington, D.C. 20008
Rhodes, Robert S., MD, 7600 Maple Ave., Apt. 707, Takoma Park, Md. 20012
Robbins, Solomon D., MD, 3011 Romaric Ct., Apt. 1, Baltimore, Md. 21209
Robinson, Kenneth M., MD, 5421 Wehawken Rd., Washington, D.C. 20016
Rodriguez, Lino R., MD, 303 50th St., W. New York, N. Jersey 07093
Rogers, John Francis, MD, 137-2A North Bend Rd., Baltimore, Md. 21229
Roman, Manuel W., MD, 12625 Safety Turn, Bowie, Md. 2D715
Rose, Philip D., MD, 1245 4th St., S.W., Washington, D.C. 20024
Roxe, David Michael, MD, 111D Fidler Lane, Silver Spring, Md. 20910
Ruas, Ernesto E., MD, 1216 E. Melbourne Ave., Apt. 2, Peoria, Ill. 616D3
Ruderman, Robert, MD, 168 Westway Rd., Apt. 102, Greenbelt, Md. 20770
Rudnai, Andrew E., MD, 1086D Spring Knoll Dr., Potomac, Md.
Rudzki, Cesar, MD, 3315 Wisconsin Ave., Washington, D.C. 20016

S

Salazar, Jose A., MD, V.A. Hospital Staff Apts., Durham, N.C. 27705
Salisbury, Robert B., MD, 5004 Corley Apt. A-8, Baltimore, Md. 21207
Salzberg, George B., MD, 1708 Flora Lane, Silver Spring, Md. 2091D
Samms, Stanley R., MD, 1505 Hamshire West Court, Silver Spring, Md. 20903
Sanchez, Andres O., MD, Northeast Florida State Hospital, Macclenny, Florida 32063
Sanchez, Carlos I., MD, 507 N. Castle St., Baltimore, Md. 21205
Satin, Lawrence, MD, 10839 Bucknell Drive, Wheaton, Md. 20902
Scanlon, Robert T., MD, 4302 Dunnell Lane, Kensington, Md. 20795
Schacter, Alvin J., MD, 4300 Garrison Blvd., Baltimore, Md. 21215
Scheidt, Peter C., MD, Highland, Maryland
Schkolnik, Ronaldo J. I., MD, 1318 Juliana Place, Alexandria, Va. 22304
Schlernitzauer, Donald A., MD, 55D N. Broadway, #608, Baltimore, Md. 21205
Schnur, James A., MD, 2211 Greenery Lane, Silver Spring, Md. 20906
Schultz, Stephen, MD, 1509 Park Ave., Baltimore, Md. 21217
Schwartz, Andrew R., MD, 1879B Glick Place, Frederick, MD, 21701
Schwartz, Michael N., MD, 721 Lewis St., Havre de Grace, Md. 21078
Schwentker, Edwards P., MD, 125 N. Homewood Ave., Pittsburgh, Pa. 15208
Seefe, Leonard B., MD, 334A Newton St., Chestnut Hill, Mass. 02167
Seymour, John C.C., MD, 13028 Victoria Hghts. Dr., Bowie, Md. 20715
Shaeffer, Charlie W., Jr., MD, 5358 Pooks Hill Rd., Bethesda, Md.
Shapiro, Bennett M., MD, Nat'l Heart Inst., NIH, Bethesda, Md. 20014
Shaw, Jon A., MD, 10508 Amherst Ave., Silver Spring, Md. 20902
Sherbourne, Donald H., MD, 617 Stevenson Lane, Baltimore, Md. 21204
Sherlock, Joel Edw., MD, 4802 Franklin St., Bethesda, Maryland 20014
Siegel, Sidney L., MD, 227 North Second St., Millville, N.J. 08332
Sightler, James H., MD, Parkwood Manor House, Apt. 29, Durham, N.C. 277D7
Silby, Howard M., MD, 920 S. Fairfax St., Alexandria, Va.
Simmons, Michael A., MD, 615 N. Caroline St., Baltimore, Md. 21205
Siple, Donald J., MD, 3003 Newton St., Wheaton, Md. 20902
Smilack, Jerry D., MD, 4793B Kingshill Drive, Columbus, Ohio 43224
Smilovitz, Donald Wayne, MD, 1700 Meridene Dr., Baltimore, Md. 21212
Solomon, Joel B., MD, 4433 Rena Ave., Forestville, Md. 20023
Sperber, Edward E., MD, 2000 McElderry St., Baltimore, Md. 21205
Stafford, Chester T., MD, 2720 Dawson Ave., Wheaton, Md. 20902
Stapen, Joseph I., MD, 155 W. 68th Street, New York, N.Y. 10024
Stark, Walter J., Jr., MD, Johns Hopkins Hospital, Wilmer Clinic, Baltimore, Md. 21205
Staufer, Wilfred B., MD, 450 Girard St., Johnstown, Pa. 15905
Steinmetz, Charles H., MD, 7300 Pearl St., Bethesda, Md. 20D14
Stern, Jack I., MD, Rt. 4, Box 321-A, Annapolis, Md. 21401
Stern, Robert, MD, 8102 Maple Ridge Rd., Bethesda, Md. 20014
Storch, Regis T., MD, 402 Edgemere Dr., Annapolis, Md. 21403
Stroud, Franklin L., MD, U.S. Naval Hospital, Bainbridge, Md.

Suarez, Jose M., MD, 1708 Aiken, Cleveland, Ohio 44109
Sugg, Joseph H., MD, Westwood Bldg., NIH, Rm. 903, Bethesda, Md. 20014
Susman, Morris H., MD, 8150 Lakecrest Dr., Apt. 813, Greenbelt, Md. 20770
Sylvester, Michael J., MD, 11427 Cherry Hill Rd., #201, Beltsville, Md. 20705

T

Tayko, Manuel E., MD, 7 Orchard St., Mullens, W. Va. 25882
Thompson, Denis N., MD, 1227 Gaylan Dr., Cuyahoga Falls, O. 44221
Thorpe, Grace S., MD, GordonTown P.O., Jamaica, W.I.
Trujillo, Nelson P., MD, 6705 Buttermere Lane, Bethesda, Md. 20034
Turbow, Myron, MD, 10607 Montrose Ave., Apt. 103, Bethesda, Md. 20014
Turkkan, Bulent Y., MD, 3515 Pike Rd., Alexandria, Va. 22310
Turner, Clifford J., MD, 1317 Dilston Rd., Silver Spring, Md. 20903
Tuthill, Dallas B., MD, 4800 Kemper St., Rockville, Md. 20853

U

Usategui, Augusto G., MD, VA Center, Dublin, Ga. 31021

V

Van Thiel, David H., MD, 445 E. 68th St., 5-P, New York, N.Y. 10021
Vasarhelyi, Laszlo, MD, 2645 Naylor Rd., S.E., Washington, D.C. 20020
Velasquez-Soto, Fernando, MD, 5918 E. Pratt St., Baltimore, Md. 21224
Vernick, Richard T., MD, 263 Congressional Lane, Apt. 503, Rockville, Md. 20852
Viamonte, Luis O., MD, Eastern Shore State Hospital, Cambridge, Md. 21613
Vincent, Gillett M., MD, 550 N. Broadway, Apt. 501, Baltimore, Md. 21205
Vola, Andrew J., MD, 106 Enchanted Hills Rd., Apt. 204, Owings Mills, Md. 21117

W

Waddill, William B., Jr., MD, 1207-Two Charles Center, 15 Charles Plaza, Baltimore, Md. 21201
Waite, Charles L., MD, 38 Esworthy Terr., Gaithersburg, Md. 20760
Walker, William P., Jr., MD, 6632 Georgia Ave., N.W., #104, Washington, D.C. 20012
Waller, David A., MD, 8D4 Reed Hall, 1620 McElderry St., Baltimore, Md. 21205
Wanuck, Stuart L., MD, 224 Long Beach Blvd., Long Beach, N.Y. 11561
Warner, Errol, MD, 590 Fulton Ave., Hempstead, L.I., N.Y. 11550
Wasserman, Barbara P., MD, 724 Carter St., Apt. 8, Rochester, N.Y. 14621
Wasserman, Martin P., MD, 724 Carter St., Apt. 8, Rochester, N.Y. 14621
Watstein, George J., MD, 5321 Glenwood Rd., Bethesda, Md. 20014
Warshaw, Josephine L. W., MD, 4317 Loyola Ave., Alexandria, Va. 22304
Weckesser, Barry J., MD, 3411 Guilford Terr., Baltimore, Md. 21218
Wellman, John, MD, 1419 Gittings Ave., Baltimore, Md. 21212
Wetcher, Kenneth, MD, 3637 Paskin Place, Baltimore, Md. 21207
Weeks, Duke B., MD, 555 Thayer Ave., Silver Spring, Md. 20910
Weintraub, Arthur H., MD, 10201 Grosvenor Pl., Rockville, Md. 20852
Wheeler, Jenette H., MD, 1336 Fairview Rd., Atlanta, Ga. 30306
Whitworth, Jay M., MD, 1150 Cedarcroft Rd., Baltimore, Md. 21212
Wilensky, Robert J., MD, 1629 Heathfield Rd., Baltimore, Md. 21212
Wilkins, Gerald W., MD, 1664 La Vista Rd., Apt. B, Atlanta, Ga. 30329
Winakur, Stuart, MD, 512 Stinchcomb Dr., Columbus, Ohio 43202
Wilson, Joe B., MD, 4251-2 Wilmington, Andrews AFB, Md. 20331
Wilson, Theodore C., MD, 6th & Bryant Sts., Washington, D.C.
Winters, Alan J., MD, 2247 Rogene Dr., Baltimore, Md. 21209
Wise, Henry A., II, MD, 1509 Fernley Rd., Baltimore, Md. 21218
Wissinger, John P., MD, 7622 Lynn Dr., Chevy Chase, Md. 20015
Wood, Dewey E., MD, 6419 Florida Ct., Springfield, Va. 22150
Wu, Wang-Kuen, MD, 3340 Gilman Terr., Baltimore, Md. 21211
Wylie, Charles M., MD, 1607 Dicken Dr., Ann Arbor, Mich. 48103

Y

Yacoubian, Jean H., MD, 9101 McDonald Dr., Bethesda, Md. 20034
Yavit, Joseph, MD, 3986 Warner Ave., Hyattsville, Md. 20784
Youngblood, John W., Jr., MD, 9 Kenlawn Ct., Towson Md. 21204

Z

Zarins, Bertram, MD, 2027 McElderry St., Baltimore, Md. 21205
Zimmerman, Jack E., MD, 303 Patton Pl., Rockville, Md. 20851
Zimmerman, Norman, MD, 2907 Fallstaff Road, Baltimore, Md. 21209
Zinner, John, MD, 5620 Greentree Rd., Bethesda, Md. 20034
Zubrod, Charles G., MD, 5813 Marengo Rd., Washington, D.C. 20016
Zussman, William V., MD, 5927 C Western Run Dr., Baltimore, Md. 21209
Zamierowski, David S., MD, 6326 Bartlet St., Pittsburgh, Pa. 15217



BOLTON HILL *Dinner Theatre*

"YEARS AGO"
April 8 — May 4

"SEPERATE ROOMS"
May 6 — June 1

Dinner Theatre—7 P.M.
Dancing 11 P.M. - 2 A.M.

FREE VALET PARKING

CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
11:30 AM - 2 AM
DINNER SERVED
5 PM - 10 PM

for Reservations
call 728-0800

Luncheon Served 11:30 AM-2 PM
Luncheon Fashion Show Every Thursday
Baltimores Only Professional Dinner Theatre

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

MEDIC 1969 SCHEDULE

OF POSTGRADUATE PROGRAMS

presented through

Medical Education's Dedicated Instructional Channel

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Prince George's General, Cheverly
Provident, Baltimore
Rosewood State, Owings Mills
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
South Baltimore General, Baltimore
Union Hospitel of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Washington County, Hagerstown

Other Locations:

Medical and Chirurgical Faculty, Baltimore
State Office Building, Baltimore
Hospital Council of Maryland, Inc., Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
539-0872

or

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201 383-3010 Ext. 8722

Supported in part by
The Medical and Chirurgical Faculty
and a grant from
Merck, Sharp and Dohme.

APRIL 25, 1969—12:30 P.M.

MALIGNANCIES OF THE CENTRAL NERVOUS SYSTEM

John A. Wagner, MD
Professor of Neuropathology
University of Maryland School of Medicine

The subject of intracranial tumor is reviewed with appropriate clinical-pathologic correlation. The salient features of the more important primary and secondary tumors is reviewed. Included also are notes on pathogenesis, relation to trauma and present status of research.

Sponsor: Frederick Memorial Hospital
Replays: Monday, April 28, 1969 12:30 P.M.
Wednesday, April 30, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

MAY 2, 1969—12:30 P.M.

CARCINOMA OF THE THYROID

Joseph B. Workman, MD
Associate Professor of Medicine
University of Maryland School of Medicine

Current knowledge concerning the causes, clinical classifications and methods of therapy in thyroid carcinoma will be discussed. Emphasis will be placed on the effect of age at onset, pathologic type, duration of disease and type of therapy upon eventual outcome.

Sponsor: Peninsula General Hospital
Replays: Monday, May 5, 1969 12:30 P.M.
Wednesday, May 7, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

MAY 9, 1969—12:30 P.M.

DIABETES

Thaddeus E. Prout, MD
Associate Professor of Medicine
The Johns Hopkins University School of Medicine, and Chief of Medicine,
Greater Baltimore Medical Center

Diabetes calls for long term management and a cooperative effort between patient and physician. The clinical problems encountered in the management of the diabetic is the subject of this presentation. Both prevention and therapy will be considered.

Sponsor: Washington County Hospital
Replays: Monday, May 12, 1969 12:30 P.M.
Wednesday, May 14, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

(Continued next page)

MAY 16, 1969—12:30 P.M.

HYPOTHYROIDISM

John G. Wiswell, MD
Associate Professor of Medicine
University of Maryland School of Medicine

A discussion of etiologic factors, unusual manifestations, and the indications for the various types of preparations used in treating hypothyroidism. The management of a patient with myxedema coma will also be discussed.

Sponsor: Anne Arundel General Hospital
Replays: Monday, May 19, 1969 12:30 P.M.
Wednesday, May 21, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.

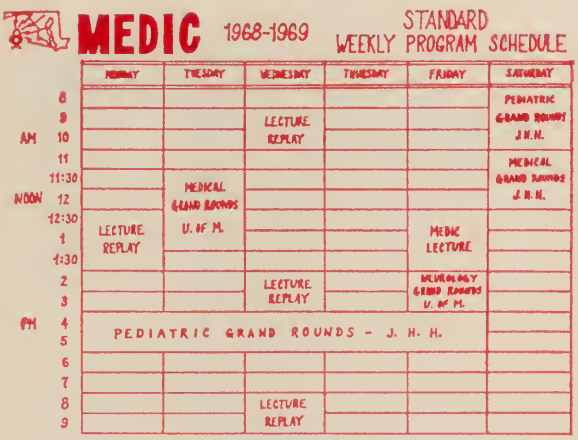
MAY 23, 1969—12:30 P.M.

CANCER RESEARCH

Nathaniel I. Berlin, MD
Clinical Director National Cancer Institute
National Institutes of Health,
Bethesda, Maryland

Cancer research will be reviewed from three standpoints. Etiology, especially our current understanding of viral etiology. New diagnostic applications, principally in cytology and mammography. Therapeutic research oriented towards where we stand with various modalities.

Sponsor: Frederick Memorial Hospital
Replays: Monday, May 26, 1969 12:30 P.M.
Wednesday, May 28, 1969
9:00 A.M., 2:00 P.M., 8:00 P.M.





WHEN YOUR PATIENTS NEED NURSING CARE

Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED
24 HOUR SERVICE ESTABLISHED 1935
BALTIMORE, MARYLAND 21229

NOW
A NEW CONCEPT
in
BOOKEEPING
and
TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

FEDERATED BUSINESS SERVICES, INC.

Box 580
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager

(It's not too early...)

MAKE YOUR HOTEL ROOM RESERVATIONS NOW

for the

SEMIANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

SEPTEMBER 4, 5, 6, 1969

HOTEL HERSHEY
HERSHEY, PENNSYLVANIA

A beautiful location, easily accessible from all sections of Maryland

FOR YOUR HOTEL RESERVATION DETACH AND MAIL THIS SLIP DIRECTLY TO:

Austin L. Mott, III
HERSHEY HOTEL
Hershey, Pennsylvania 17033

Name .....

Address ..... City ..... State .....

Please reserve ..... rooms No. of persons.....

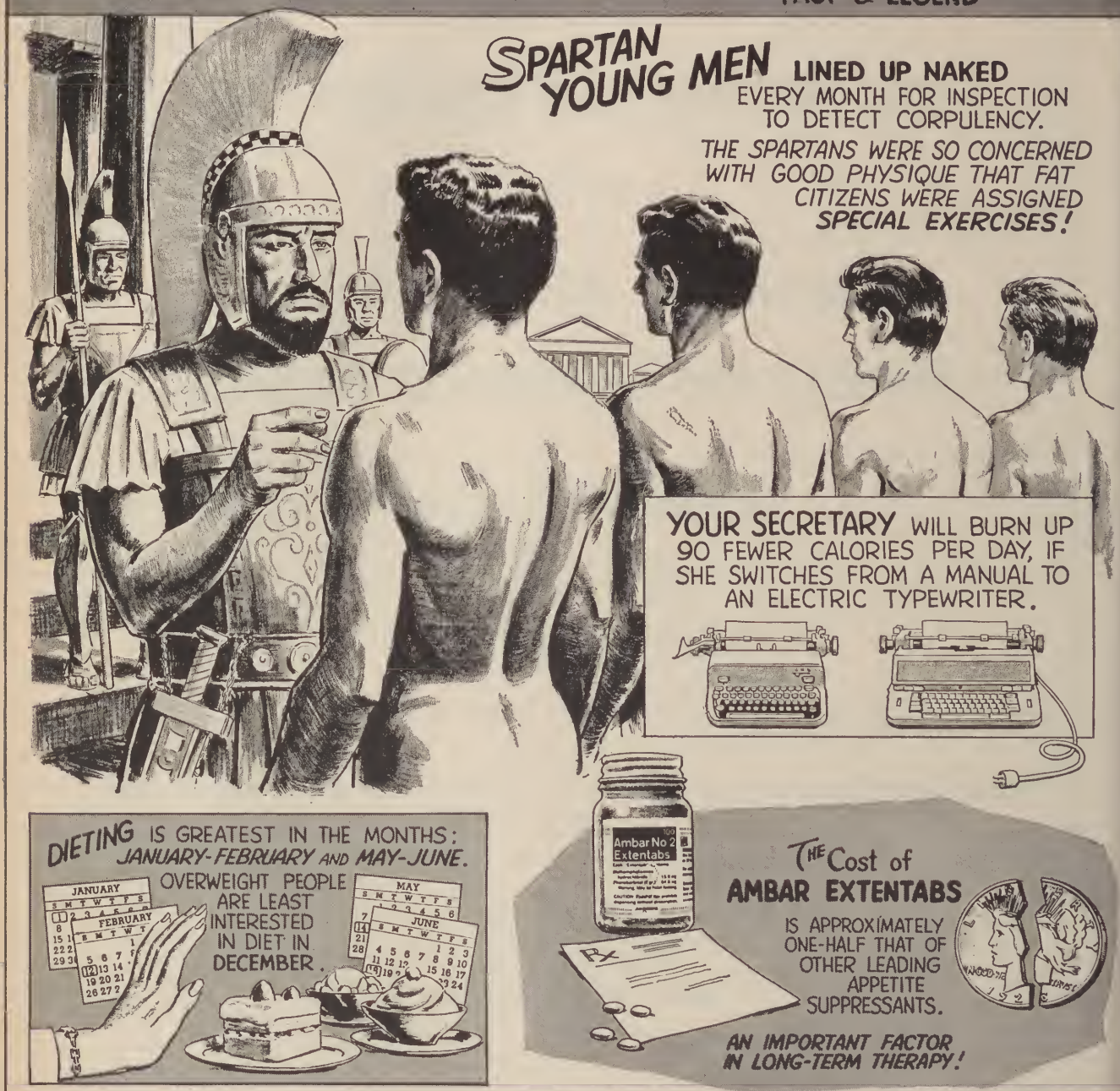
Date of arrival ..... Date of departure .....

Attending Semiannual Meeting of the Medical and Chirurgical Faculty.
All requests subject to confirmation.

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220

A·H·ROBINS

See next page for prescribing informatio



You've made it one of your specifics in acute otitis media

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE



You've made it one of your specific in acute otitis media

DECLOMYCIN acts against many strains of H. influenzae, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strain may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged actio permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocoli pruritus ani. Skin—maculopapular and erythematous rashes; a r case of exfoliative dermatitis has been reported. Photosensitivi onycholysis and discoloration of the nails (rare). Kidney—rise in BU apparently dose-related. Transient increase in urinary output, son times accompanied by thirst (rare). Hypersensitivity reactions—u caria, angioneurotic edema, anaphylaxis. Teeth—dental staining (y low-brown) in children of mothers given this drug during the latter h of pregnancy, and in children given the drug during the neonatal pe od, infancy and early childhood. Enamel hypoplasia has been seer a few children. If adverse reaction or idiosyncrasy occurs, discontir medication and institute appropriate therapy. Demethylchlortet cycline may form a stable calcium complex in any bone-forming tiss with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Sho be given 1 hour before or 2 hours after meals, since absorption impaired by the concomitant administration of high calcium conte drugs, foods and some dairy products. Treatment of streptococ infections should continue for 10 days, even though symptoms h subsided.

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 3 mg, 150 mg and 75 mg of demethylchlorte cycline HCl.

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York

Lederle

THE DAY OF THE LONE (INSURANCE / MUTUAL FUND) WOLF IS OVER

AN INCREASINGLY COMPLEX AND SOPHISTICATED WORLD HAS PASSED HIM BY

WE ARE A TEAM OF SPECIALISTS

ON OUR TEAM IS A SPECIALIST IN KEOGH PLANS
(HIS ARTICLES IN THIS FIELD ARE NATIONALLY KNOWN!)

ON OUR TEAM IS A SPECIALIST IN MUTUAL FUNDS
(IN CONSTANT CONTACT WITH OLD FRIENDS ON WALL STREET!)

ON OUR TEAM IS A SPECIALIST IN TAX-SHELTERED METHODS OF PURCHASING LIFE-INSURANCE AND MUTUAL FUNDS
(18 YEARS IN THIS FASCINATING AND COMPLEX SPECIALTY!)

ON OUR TEAM IS A SPECIALIST IN ACCIDENT AND SICKNESS INSURANCE
(30 YEARS IN THIS SPECIALTY!)

ON OUR TEAM IS A SPECIALIST IN ESTATE PLANNING
(KNOWN AND RESPECTED AS BOTH TEACHER AND PRACTITIONER!)

ALL THESE PEOPLE ARE AT YOUR SERVICE
(HOW CAN ONE MAN POSSIBLY COVER ALL THIS GROUND–IN DEPTH?!)

SECURITY HOUSE, Inc. and affiliates

539–5900

THE HOUSE OF SPECIALISTS
(IN INSURANCE AND MUTUAL FUNDS)


BALTIMORE
COUNTY
ANNE ARUNDEL COUNTY
PATAPSCO RIVER
NORTHWEST BRANCH
MIDDLE BRANCH
PATAPSCO
1
2
3
4
5
6
7
8
9
10
11
12
13
14
1
2
3
4
5
6
7
8
9
10
11
12
12A
8A
SPRING
STEVENSON RD
JOPPA ROAD
RUXTON
TOWSON
BURKE AVE
HILLEN
EUDOWOOD
SHEPPARD PRATT HOSP
STATE TEACHERS COL.
COUNTRY CLUB OF MARYLAND
LAKE ROLAND PARK
BONNIE VIEW GOLF CLUB
DRUID RIDGE CEM
REISTERSTOWN ROAD
COURT ROAD
JONES FALLS EXPRESSWAY
RAVEN BOULEVARD
(PROPOSED)
HARFORD RD.
FULLERTON
BELAIR RD.
BELTWAY
RALSTON
PARK
WEIGHTS
NORTHERN PARKWAY
UNIVERSITY OF BALTO
HAPPY HILLS CONV HOME
PIMLICO RACE TRACK
SINAI HOSP
MOUNT PLEASANT PARK
LOCH RAVEN
PERRING
OVERLEA
HAMILTON
HAZELWOOD AVE
GOVANS
CHARLES STREET AVENUE
YORK ROAD
BELVEDERE AVENUE
ROLAND PARK
GUILFORD
UNIVERSITY PKWY
ROLAND AVE
SPRING LANE
PIMLICO AVENUE
COLD SPRING LANE
ARLINGTON
LIBERTY ROAD
CHILDRENS HOSP
HAMPDEN
JOHNS HOPKINS UNIVERSITY
ART MUSEUM
33RD ST
UNION MEM HOSP
BALTIMORE MEMORIAL STADIUM
MONTEBELLO (STATE) HOSP
FRANKFORD AVENUE
THRUWAY
PHILADELPHIA
PULASKI H
FOREST PARK
DRUID HILL PARK
ZOO
CLIFTON GOLF COURSE
CLIFTON PARK
FERDAN AVENUE
HARBOR TUNNEL
ROSEDALE
WALBROOK
GWYNNS FALLS PK/W
HANLON PARK
HERMAN HOSP
CITY COUNTY
MILL OAK ROAD
GWYNN OAK
CURITY
SOCIAL SECURITY ADM.
NORTH AVENUE
PRESTON STREET
BIDDLE ST
MADISON STREET
ENUMENT ORLEANS STREET
JOHNS HOPKINS HOSPITAL
BROADWAY
PATTERSON PARK AVE
MONROE STREET
FULTON AVENUE
DRUID HILL AVENUE
McCULLOH STREET
PENNSYLVANIA AVE
CHARLES STREET
ST PAUL STREET
GREENMOUNT AVE
LEAKIN PARK
GWYNNS FALLS PARK
BALTIMORE NATIONAL PIKE
EDMONDSON AVENUE
FRANKLIN STREET
MULBERRY
FRANKLIN SQUARE HOSP
BALTIMORE
LOMBARD
FAYETTE ST
CONKLING
BALTIMORE CITY HOSP
EASTERN AVENUE
OLD FREDERICK RD
HILTON ST
PRATT STREET
PATTERSON PARK
HIGHLANDTOWN
BOSTON ST
MERRITT PARK
MERRITT BOULEVARD
DUNDALK AVENUE
DUNDALK
INGLESIDE AVENUE
FREDERICK AVENUE
PINE CREST SAN
LOUDEN PARK CEM
CANTON
HOLABIRD AVENUE
RUSSELL STREET
HANOVER STREET
KEY HWY
McCOMAS ST
FORT AVE
WEST BALTIMORE
WILKENS AVE
WASHINGTON BLVD
CATON AVENUE
SPRING GROVE STATE HOSP
ROLLING ROAD COUNTRY CLUB
WESTPORT
PONTE ST
ARBUTUS
HALETHORPE
ALT 1
SOUTH WESTERN
HANMONS FERRY RD
ANNAPOLIS ROAD
THRUWAY
RELAY TUNNEL
HARBOR
NURSERY RD.
OLD BELLE GROVE ROAD
PATAPSCO AVE
PENNINGTON AVE
BROOKLYN
CURTIS BAY
RITCHIE HIGHWAY
CHERRY HILL LANE
DEPT OF MOTOR VEHICLES
ELKRIDGE
BALTIMORE - WASHINGTON
FORT MEADE
LINTHICUM
FERNDALE
GOVERNOR
FRIENDSHIP INTERNATIONAL AIRPORT
PARK RIVER
BALTIMORE BALTIMORE

Restaurants of Distinction

Locations indicated by numbers on map

9

Cork 'n Bottle Restaurant

STEAK — SEAFOOD — PRIME RIB
COCKTAILS
LUNCHEON — DINNER

Major Credit Cards Honored
Private Party Rooms

2 E. FAYETTE ST. BALTIMORE, MD.

½ Block from Charles Center

539-1268

3

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION
Baltimore's Finest Italian Restaurant
THE LEISURE COCKTAIL LOUNGE
5 minutes from Baltimore Civic Center
Open 12 noon to 3 A.M.—Closed Mondays
For Reservations Call 685-2811
2 blocks south of the Flag House
300 ALBEMARLE STREET

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER
ROOFTOP RESTAURANT
Phone 433-8018

1

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*

Your Host
Tom d'Anna

539-9021



12

Dobbs House

Breakfast-Luncheon-Dinner
Banquets-Meeting-Private Parties
We Cater Wedding Receptions

Located in Quality Court Motel—West
U.S. Route 40 & Beltway Exit 15
5801 Baltimore National Pike

744-1510

4

Broadview Restaurant

Cocktails • Dinners • Luncheons
Private Entertaining Facilities
116 W. University Parkway at 39th St.
CALL CH 3-1216

5

MILTON INN

Circa 1740

Dine Amid Early American Charm
Warm, Gracious and Inviting

Selected By Life & Time Magazines
as One of America's Finest Inns

Lounge & Dining Room Available
for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.
PARKS 771-4366

7

Miller Bros.

"The Place to Eat"

NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call 752-4822

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE
Baltimore 1, Md. MU 5-6790

CARRY-OUT SERVICE
SPECIAL LUNCHEON and DINNERS
PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.
Sunday 12 Noon to 3 A.M.

0

Club Venus

SPECIAL AT THE
FABULOUS CLUB VENUS
An Evening for Two . . Only **$15**
Offer good every night except Saturday
Make Reservations Now
erring Plaza Shopping Center—Beltway Exit 30
For Reservations Call NO 8-2232

5

Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS
Finest Sea Foods
Prime Meats

5653 Old Frederick Road
East of Ingleside Ave., off Baltimore National Pike

TED KUCHTA, *Manager* Phone 744-0223

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD
Cocktails Mexican Beers

Tuesday thru Sunday
Open 5:00 P.M.---12:00 P.M.
Dinner and Snacks
Closed Monday

Phone 435-9858

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.

Miss Gladys Deeds
Manager

213 West Saratoga St. 727-7011



PLANNING, ENGINEERING, INSTALLATION & SERVICE

We Feature AMPEX

VIDEOTAPE RECORDING EQUIPMENT

Call Today for a Free Demonstration

high fidelity house

6307 YORK ROAD BALTIMORE, MD.
(Drumcastle)

Phone 323-3713

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational aotivities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

CHARLES W. NEVILLE, JR., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—253-2761

A "cold" fact



NTZ® delivers relief of nasal symptoms

The *first spray*—1 or 2 squirts—of NTz opens the inferior part of the common meatus. The *second spray*, a few minutes later, shrinks the turbinates to promote adequate sinus drainage and ventilation—to help prevent sinusitis. Dosage may be repeated every three or four hours.

The fact is, NTz is more than a simple vasoconstrictor. It contains:

Neo-Synephrine® HCl 0.5%, a decongestant of unexcelled efficacy (in full adult strength) to shrink nasal membranes and allow comfortable breathing.

Thenfadil® HCl 0.1%, a topical antihistamine to help relieve itching and rhinorrhea.

Zephiran® Cl 1:5000, an excellent wetting agent and antiseptic preservative to aid rapid spread of components.

NTz, for temporary relief of nasal symptoms, is well tolerated, but overdosage should be avoided.

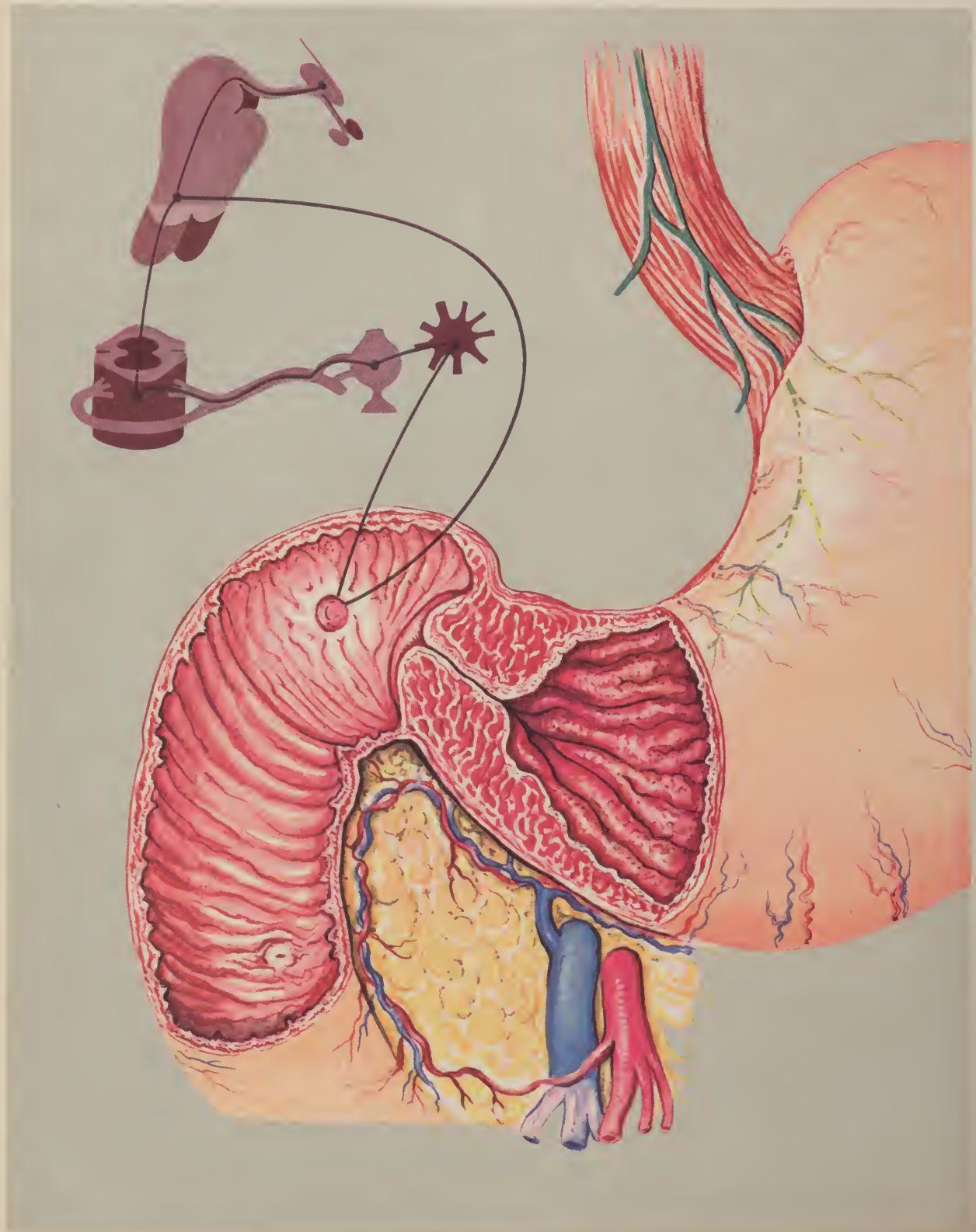
Available: NTz Nasal Spray in squeeze bottles of 20 ml.; NTz Solution in bottles of 1 oz. with dropper.

Winthrop

Winthrop Laboratories, New York, N.Y. 10016

(1286M)

Healing the ulcer crater



Pro-Banthīne®

brand of

propantheline bromide

blocks ulcerogenic autonomic impulses

Therapeutic Activity—Pro-Banthīne blocks ulcerogenic impulses at both parasympathetic effector sites and ganglia and at sympathetic ganglia.

This dual action, a capacity quite beyond that of belladonna derivatives, has been shown repeatedly to reduce gastric secretion, to suppress gastrointestinal motility and to relieve ulcer pain.

Healing Environment—Thus, Pro-Banthīne, together with other standard measures, creates a favorable environment to hasten healing of the ulcer.

So widely is this ability recognized that for years Pro-Banthīne has been the most widely prescribed medication for treating peptic ulcer.

Indications: Peptic ulcer, gastroenteritis, pylorospasm, biliary dyskinesia, functional hypermotility and irritable colon.

Contraindications: Glaucoma, severe cardiac disease.

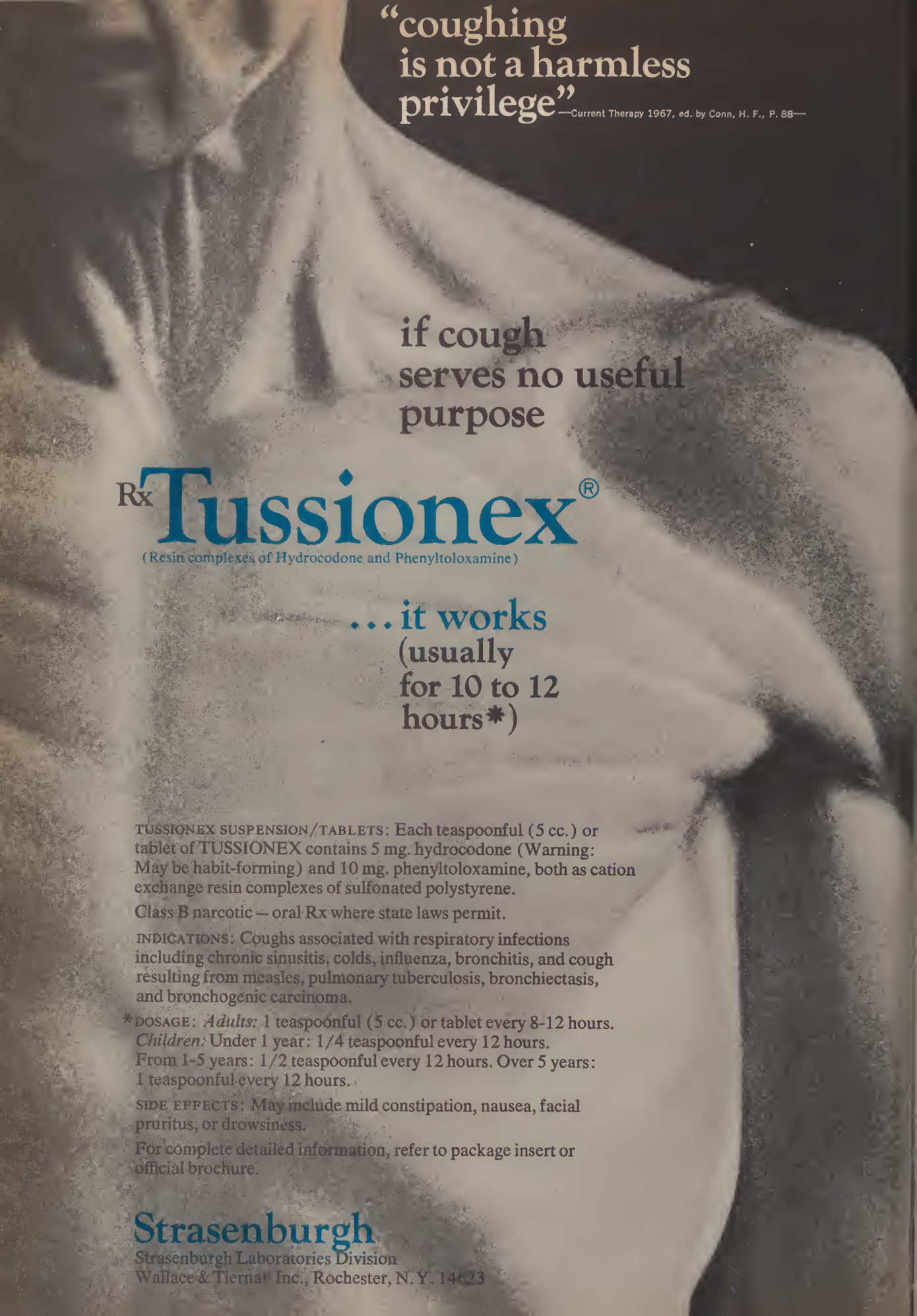
Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal tolerated dosage is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two tablets four to six times daily may be required. Pro-Banthīne (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

981 4/69

SEARLE *Research in the Service of Medicine*



"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—

if cough serves no useful purpose

Rx Tussionex®

(Resin complexes of Hydrocodone and Phenyltoloxamine)

... it works (usually for 10 to 12 hours*)

TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

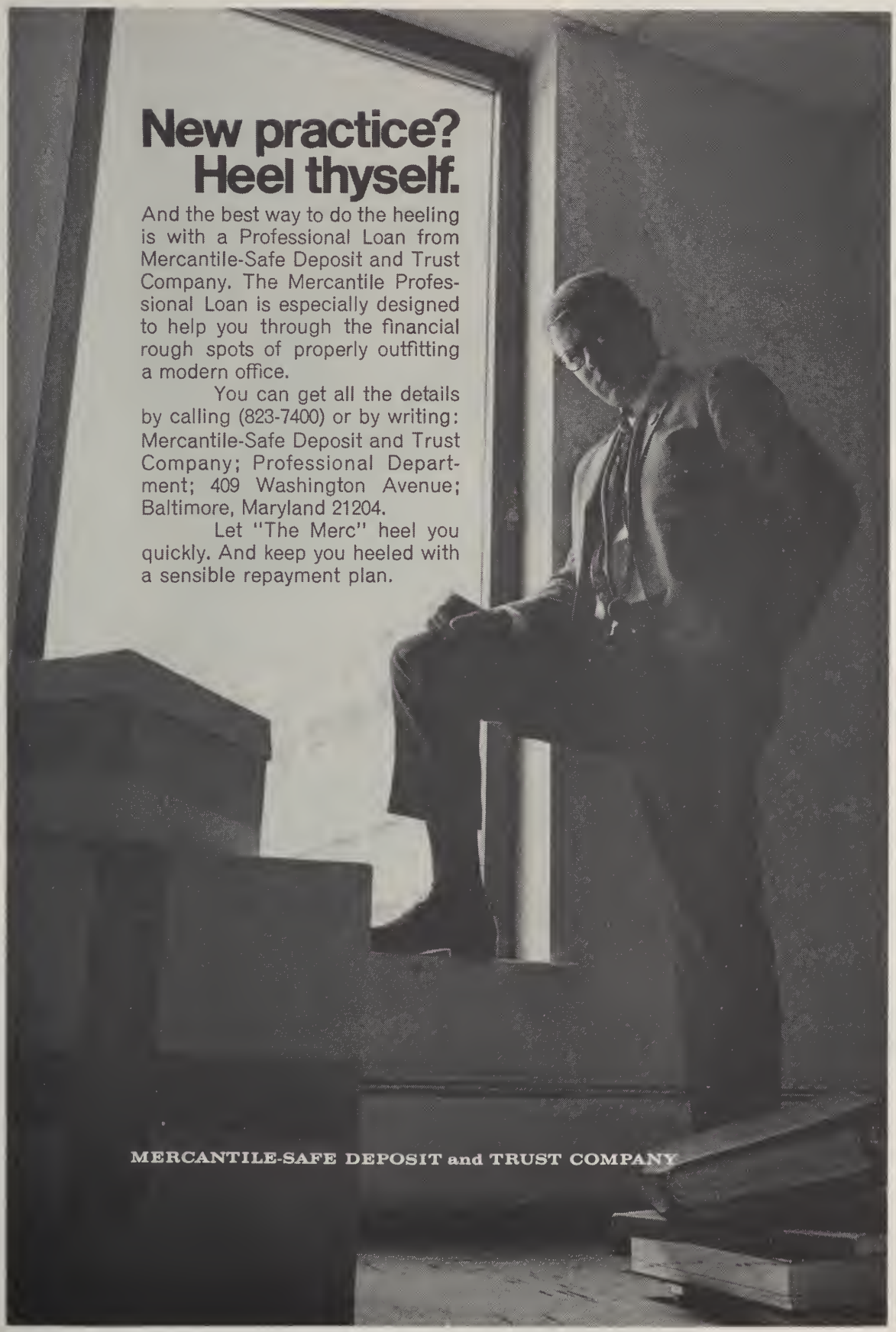
*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623


New practice?
Heel thyself.
And the best way to do the heeling is with a Professional Loan from Mercantile-Safe Deposit and Trust Company. The Mercantile Professional Loan is especially designed to help you through the financial rough spots of properly outfitting a modern office.
You can get all the details by calling (823-7400) or by writing: Mercantile-Safe Deposit and Trust Company; Professional Department; 409 Washington Avenue; Baltimore, Maryland 21204.
Let "The Merc" heel you quickly. And keep you heeled with a sensible repayment plan.
MERCANTILE-SAFE DEPOSIT and TRUST COMPANY


"I feel
so light-
headed..."

She's confused...and frightened. Yesterday, her complaint was a brief spell of dizziness. Next week, she may be troubled by prolonged nausea or tinnitus. The symptom of vertigo is a constant problem in geriatrics, and regardless of origin, duration, and frequency, such episodes can result in severe emotional and physical discomfort for the aging patient.

You can help prevent such problems with

BONINE®

(MECLIZINE HCl)

protects most patients against nausea and vertigo up to 24 hours with a single dose.

Whether the symptoms are due to Ménière's syndrome, labyrinthitis, vestibular dysfunction, or cerebral arteriosclerosis, most patients with nausea and vertigo respond remarkably well to Bonine (meclizine HCl). A single dose usually protects up to 24 hours. In difficult cases multiple daily doses may be necessary for maximum response.

One-a-day dosage costs your patients less. And fruit-flavored Bonine chewable tablets are more convenient to take anytime, anywhere—without water. Side effects are infrequent and mild, even with prolonged use.

Precautions: Although the incidence of drowsiness and atropine-like side effects such as dry mouth and blurring of vision is low, the physician should alert the patient to the need for due precautions when engaging in activities where alertness is mandatory. *Use in women of childbearing age:* In weighing potential benefits vs. risk in women of childbearing age, consider the fact that a review of available animal data reveals that meclizine exerts a teratogenic response in the rat. In one study a dose of 50 mg./kg./day (50 times the maximum recommended human dose) produced cleft palate in 2 of 87 fetuses when administered to the rat at critical times during the first 15 days of gestation. At doses of 125 mg./kg./day, meclizine will produce 100% incidence of cleft palate in the rat. At doses of 25 mg./kg./day, decreased calcification of the vertebrae and relative shortening of the limbs were also produced in the rat, but experts disagree as to whether this is a teratogenic response. While available clinical data are inconclusive, scientific experts are of the opinion that this drug may possess a potential for adverse effects on the human fetus. Consequently, consideration should be given to initial use of a nonphenothiazine agent that is not suspected of having a teratogenic potential. In any case, the dosage and duration of treatment should be kept to a minimum.

Supply: 25 mg. scored tablets.

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

The Age of

"Harmony and understanding,
Brotherhood and trust abounding . . .
This is the Age of Aquarius . . ." —Hair

The production of "Hair" has revived an astrological fact, which has been in operation since 1904. To many, the Age of Aquarius may sound like a superstitious bunch of bunk. But to many others—the younger generation specifically—its power of suggestion is strong enough to transform starry predictions on a page to the really real. It's not just enough to know what age we're in; and rather than make the astrologers look like bloomin' fools—which they have appeared to be to all nomenclators, with the exception of ardent housewives, we'd rather make ourselves look like gods. ("I believe in God and God believes in Claude—that's me.") This isn't so hard to do if you take a walk in space by launching an LSD cloud or levitate to a cinemascope vision in a Yoga meditation. But to the ones who are just beginning, and to the ones who are left over from the nondescript generation, it's downright exasperating. It is especially frustrating to those who have chosen to walk the quietly militant road of freedom only to discover that the world cannot be remolded as easily as an aquarian pours water over a barren earth.

Aquarius

Nevertheless, instead of folding their napkin and
leaving the table—which is what they claim
the previous generation did—they promise a roar so
deafening, and so compelling that the world will
break into crescendoes of love and brother-
hood and, at last, peace.
So when names are recorded in the stars, these
are the persevering ones who will shine the
brightest—not the observers who find the water too
turbulent for their tepid natures, and who still
persist in living in the twilight zone, nor
the ones who dismiss the world with a wave
of the hand on their way to outer euphoria.
In the end, the history books may revert to
astrology books to define this Age of Aquarius, and
in doing so we hope they don't miss the
bold print: "The stars impel, they do not compel!
What you make of your life is largely up to you."

the 20th Century adolescents

The Adolescent Patient:

An Overview

SHELDON D. GLASS, MD
Co-Director, Family and Youth Center
Dept. of Psychiatry and Behavioral Sciences
The Johns Hopkins University School of Medicine

The papers presented on the following pages are from the symposium on the 20th Century Adolescent, held November 13, 1968 at the Eastwind in Baltimore. The symposium was sponsored by Geigy Pharmaceuticals and the Medical and Chirurgical Faculty.

The 20th Century Adolescent is a topic which in recent years has stirred the interest and demanded the attention of the entire nation. We have had overt rebellion from our adolescents. They are demanding IN. They want "a piece of the action."

Adolescence has been defined in many ways. The definition that I like best is the one which states that adolescence is the time when your son stops asking you where he came from and starts telling you where to go.

Biologically, adolescence can be considered to begin with the first evidence of physical sexual maturation and end with the complete development of primary and secondary characteristics. Psychologically, adolescence may be different in various individuals from diverse cultures. Young adults who are chronologically and physically adults may be psychologically adolescents. Comparative studies of different cultures have shown that environmental factors do influence the reaction of the adolescent and his psychological development. This is important to note in therapy. Man is an adaptive animal and will respond to his environment.

Although internal stimuli, such as the increase in aggressive and sexual drives during adolescence, are important factors, environmental factors are equally significant. In some instances, they may be more important in influencing the psychological development of the individual and in affecting his ability to handle these internal factors.



Courtesy of the News American
Photo by: Richard Tomlinson

Because many changes occur in the adolescent, both internally and externally, he is more anxious. This is reflective of the changes within himself, and his interaction with the environment. For this reason—and this is where I perhaps differ from some of my colleagues—I insist that all the members of the family, or at least the parents and the patient, be present for an opportunity to communicate with each other. Sometimes, the family or the parents of the individual patient may not be ready for this in the initial phases of treatment. However, I program it so that both the patient and the family know that this will eventually come about when I think it is technically in the best interest of the treatment plan. (This has been called conjoint family therapy.)

When the adolescent is still in high school and living at home, I insist upon this treatment program, with some exceptions of course. If the patient has moved on to college or is not living at home, then I may or may not work with the family, depending upon the technical advantages and disadvantages to both the patient and the parents. If we don't consider interaction with the family, I think we place the patient at a disadvantage. In a structured setting, such as the physician's office, the patient can identify with the physician and gain confidence in his development of independence. In addition, the parents can gain on-the-spot insight into the way they relate to their youngster, and have an opportunity to reflect on their own ideas.

More and more, the generation gap is being brought to my attention. The other day a youngster, who was working through an identity problem by lifting weights, came in. I noticed he was starting to develop muscularly. I said to him "You're beginning to look like Charles Atlas." And he looked at me and replied, "Who's Charles Atlas?"

Another situation occurred a few days ago in a seminar that I was involved in—and I thought this was very fascinating. A boy was referred because he was expelled from school for smoking on the school grounds. When the person who was presenting the case history paused, five people immediately reacted by saying, "What was he smoking cigarettes or marijuana?"

During development the adolescent is concerned with many things. I am going to take the liberty of grouping them into three main categories, although each is not a separate entity.

The first is body image. The adolescent has significant growth spurts. His body is changing, he gets gawky at times. He has a tremendous appetite, and he occasionally gets acne. This influences the adolescent considerably; he becomes self-conscious.

We had a youngster who was referred to a group counseling program in one of our schools because he wasn't participating within the classroom. It was only until the second session, when he did start to participate, that we recognized the reason for his isolation in the classroom. He was constantly keeping his hand over his mouth because his two front teeth were missing. This was the primary reason for his non-participation in the class.

The second consideration is that of identity: Who am I? One youngster who I had been treating about a year ago came in one day and said, "You know I was working with my mother in the kitchen. We were both doing dishes, and I suddenly recognized that I was who I was and she was who she was and that we were different people." This is significant to the youngster. He is trying to determine his own identity.

Identity itself can be divided into two parts. One is the concept of oneself as an individual, and the other is the concept of oneself as a member of the group. Although these identities are closely related and transact with one another, they are different.[2]

Group identity is important during adolescence. If you have a youngster who isn't socializing and doesn't have peer relationships, then you ought to review the situation closely. One of the most significant examples of this phenomenon is seen in the inner city schools. On individual examinations the youngsters may have significant self-esteem and self-worth. They are healthy, strong boys and girls, but they are not performing in the class. One of the reasons for this is that they adapt to the environment of the class, which may be one of non-learning. In order to survive, they have to conform to the group. As a result, their conformity interferes with the educational process that the school is trying to promote.

On the perimeter of the city this also can be a problem. Youngsters may be in groups in which everyone is going to a "big league" college, such as Harvard, Yale, Cornell, Hopkins, Radcliffe, and Wellesley. When a youngster can't quite make that league, then he may be in trouble, because he may feel he can't identify with his peers.

This is also important in families. (The family

is the primary group.) Everyone in the family assumes a role as part of the family unit. While the youngsters are developing their independence, they must decide what their role is and has been in the family, and then decide what their role is or can be outside the family.

Gradually the adolescent should be given the opportunity to develop from a dependent position in early adolescence to an independent one. However, when he does, it creates some of the difficulty that we often observe within the adolescent youngster. As his mood fluctuates, he assumes a very independent position, telling his parents he's going to do it "this way," to the point that his parents are almost ready to kick him out of the house. Then he says, "Well, I'm not ready to be that independent", and he becomes exceptionally nice. Then, of course, he gets too close. He can't tolerate this, so he swings to the opposite extreme again. This explains in part, though not totally, the mood vacillations in adolescence. It is during periods such as these, that bringing the entire family together to orient them to the change of the adolescent, as well as themselves, is particularly helpful. Sometimes we spend so much time with the individual adolescent that we forget that he has parents, who are also going through a change.

The most difficult change for the parent is one of separation from his youngster as the youngster becomes more independent. This means that not only the role of the youngster is changing, but also the role of the parents in relation to that youngster. Sometimes this is not as easy for the parents as we may believe. The question of dependency, of not wanting to let go, is one on which the parents must reflect. The fact that they also are reliving their own adolescent experiences may influence their attitude and their reflections on their own children. This, in turn, may be complicated by the appearance of the Oedipal problem. Since the daughters and sons are becoming more attractive, both adolescents and their parents are becoming more sensitive and aware of each other.

During the period of adolescence, there is a revolt against parental authority. It is important that the parents set limits. This, I believe, is a group dynamic. The youngster will know where he can go and where he can't and where he can draw his battle lines for independence. It gives structure within the primary family group, which is essential, so that everybody can adapt and readapt accordingly.

I had one youngster who was referred to me because he became a high school dropout. I asked him why he became a dropout. He said, "Well, the first thing I did was I grew long hair, and nobody paid any attention. The next thing I did was that I wore dungarees, and nobody paid any attention. The next thing I did was I started to do poorly in my grades, and nobody paid any attention. But when I dropped out of school, that's when they started paying attention."

Because the youngsters are trying to become independent, they do need parents to interact and to conflict with. It's better to draw the battle lines along things like long hair and clothes, than schooling.

Another consideration would be the expectancy effect. Sometimes parents expect their youngsters to do certain things and, in fact, the youngsters do attempt to fulfill the fantasies, and wishes of the parents. I think this is important to consider.

Are the kids of today different from the kids of yesteryear? I'd say, yes, they have to be, if we are adaptive social animals. In the last twenty-five years we've had three wars, which have affected every family, either directly or indirectly. We now can have charter flights to the moon for Christmas, and this is an important consideration in time and space. We have weapons that can annihilate mankind, which have to affect the entire community. These factors influence all of us, not just the adolescent.

But I think that one of the primary considerations now facing our adolescents can be called the "opportunity gap." Technological advances have outdistanced our current social models. Parents ask me, "What can I do? There are no jobs available for the kids. What is there to do at home? We have automatic everything." This is the challenge. We have to redesign our socialization concepts to give our youngsters an opportunity to participate. They want in. They want to communicate with people, their parents and their friends. They want an opportunity to do something worthwhile. They want to be able to tackle new jobs. The kids of today are sophisticated and they're smart. Like any adolescent of most generations, they have tremendous enthusiasm and energy; like any adolescent they are willing to get involved.

We have to redesign our institutions, such as, our public schools, our colleges, our universities, and our community programs. This must be done on a local and state basis so that the youngsters can get involved in organized

activity enabling them to test themselves, to expand their ideas, and to develop their creative ability in ways that perhaps we haven't conceived of before. Until we are able to do this, we are going to have adjustment problems in adolescents, and we're going to be seeing more and more adolescents as patients.

Good medicine is also prophylactic medicine. We should be able to talk with and treat the adolescent, but we should also participate in our community activities. In this way we can help bring about the changes, which are so necessary, to allow our youngsters to participate in the community in a meaningful way. Part of this redesign has to be and should be done by the adolescents themselves. Nevertheless, when we can invite them to participate with us to design programs for them we will be beginning to bridge the opportunity gap that currently exists for our adolescents in the 20th century.

REFERENCES

1. Schonfeld, William; The Adolescent in Contemporary American Psychiatry, *Inter. J. Psychiatry,* Vol. 5, No. 6, p. 470, (June) 1968.
2. Glass, Sheldon D.; The Practical Handbook of Group Counseling. p. 9 (to be published summer 1969).

Implications of the Sex Revolution in the Adolescent's Search for Sexual Identity

JAMES F. MASTERSON, JR., MD
Associate Professor of Clinical Psychiatry
Cornell University Medical Center;
Attending Psychiatrist
Payne Whitney Clinic
New York, New York



Courtesy of the News American
Photo by: Frank Spinek

Perhaps the main implication of the sexual revolution is the fact that the topic is mentioned almost always in the course of everyday conversation. It has been taken out of the bedroom and into the living room. There are a number of reasons for this, I think. Everyone has, or had, sexual conflicts in his development which he resolved to, perhaps, a relative degree. Still, he wants to know more about them. As a result, he goes to hear talks or read articles about the sexual revolution, since he feels he is involved in it too.

Now, we are not just living in a time of sexual revolution, but also in a time of social revolution that is just as vast, as profound, and as sweeping as anything since the period of the Renaissance. It involves a complete restructuring of the relationship of the individual to authority which places much greater stress on the needs and rights of the individual, and the necessity of the various figures of authority to rely more on reason and flexibility, rather than on rules and discipline in their dealings with the individual.

This begins obviously in the home, in the relationship between parents and children. It's followed through in the schools in the relationship between the school and the student; and in the society as a whole in the relationship between the citizen and the laws and the courts, the employer and employee; and in religion between the hierarchy and the laity. People are demanding not only that they be given adequate consideration, but that they also participate with the authority in the decisions involving their own destiny. There are numerous examples of this every day in our newspapers. Even in my own home it filters down. My 11-year-old son is a good example. He was leaning over the bed one day and I gave him a boot on the backside, sending him sprawling over the bed. And he turned around and said, "Parental brutality, an invasion of my rights."

You also hear a great deal about students rioting because they want more voice in the government of their schools. Also, in medical schools today the students are joining with the faculty in planning curriculum. And coming from New York City as I do, I don't have to look very far for examples of conflicts between employer and employee. We have them everywhere: policemen, firemen, sanitary engineers, teachers. As far as the law is concerned, I guess everyone is familiar with the Supreme Court decisions elaborating on the legal rights of suspects in the court. In religion too, there is enormous turmoil in the Catholic Church. So in essence, authoritarianism as we've known it through the years is out, and humanism is in. I think this augers very well for future generations in that it represents a dismantling of the remaining fragments of medieval thinking in the minds of men, and promises a future race that is more reasonably oriented and, hopefully, more responsive to human needs.

It's not surprising, then, that as part of this over-all social revolution we have something of a sexual revolution. Mankind is undergoing another dramatic swing of the pendulum in its effort to integrate harmoniously its sexual impulses and its social values. The evidence for this is also everywhere. The newspapers report that students are insisting that sex is a private matter and demanding the right to entertain girls in their rooms. A few months ago, the *New York Times* reported that the Columbia authorities turned this decision over to the student council, who decided there would be no rule at all about entertaining girls in their rooms.

Presently, the pill is much more widely used. The divorce rate is rising, and the percentage of those who have not had sexual intercourse before marriage is falling. The ancient fears of disapproval, of disease, of death, and of damnation are losing their former sway.

Now are these changes only in attitude, or are they also manifested in behavior? Are they the views and actions of a prophetic minority, of a fools' group, or the wave of the future? Is this revolution or evolution? Will it lead to a decline of social morality, or to greater human happiness? Is it only among the young, or does the older generation participate also? And why is it happening now? I am going to present a few thoughts on these questions, and also on some of the implications of these changes for the adolescent's struggle to develop his own sexual identity.

Many of the elders, I mean those over 40, view changes from the perspective of their own development, which is one based, for the most part, on Judaic-Christian ethics. Those with strict concepts of sexual morality have tended to see these changes as a sexual revolution and to ascribe them mostly to youth. It seems to me that they may err on both counts; for not only is this ferment taking place among adults, but also what we call revolution—meaning the overthrow of an established system of morals—the younger generation may view as evolution—the process of growth and development toward a new system of morals.

Let's look first at the adult world for signs of change in law, religion, and medicine.

In religion, the Catholic Church, more responsible than any other single agency for the prevailing concepts of sexual morality that have guided western man for the last 2,000 years, is in a furor at the present time, with congregations walking out on bishops, and bishops disagreeing with the Pope.

Concerning the law, there's a great desire throughout the country to liberalize abortion laws.

A recent survey of psychiatrists indicated that 95% felt that the law should be more liberal. Efforts to achieve this end recently just barely failed in New York, but, as you probably know, did succeed in Colorado. Thus, the law's views on sex are being revised.

Medicine, too, is changing in regard to sex. For the first time in the history of mankind, the light of reason in the form of experimentl scientific study has been introduced into the superstition, mystery, and the darkness that has surrounded human sexuality by Masters and Johnson's unique and pioneering studies of human sexual behavior.

These changes in religion, in law, and in medicine cannot be attributed only to youth. Clearly, the older generation, those charged with preserving, protecting, and transmitting the values of our culture, are actively involved in modifying these very same values. Meanwhile, what is happening among younger people? While their elders, being under less immediate pressure from sexual feelings, cope with these issues in a sober and intellectual fashion, the younger people, under more urgent pressure, have tried to apply these new concepts to their own lives.

Authorities differ as to the extent of premarital intercourse among students, but there is a consensus that the double standard increasingly has been discarded. College girls more often seek sexual experience during the college years than their mothers did. And there is evidence of earlier biological maturation in adolescence and a widespread pattern of going steady and of more open and vocal discussion of sex.

How extensive is this change? Though I read much in the press about the increased sexual freedom of the younger generation, I see less of it in my office and I read less of it, even in my own professional publications. My guess is that the advance guard of the younger generation is indeed exhibiting a great deal more sexual freedom, but that the majority, while still holding to traditional patterns in their behavior even as their parents did, are at the same time submitting their concepts, previously taken for granted, to serious and searching scrutiny. In other words, there's more change in attitude than in behavior. This view was recently supported in a study by Halleck of Wisconsin who found in his survey of college girls that although 70% thought there was nothing wrong with premarital sexual intercourse, only 22% had actually engaged in it.

I think there is more actual change in behavior in an older group in their mid-twenties. The teen-agers are not showing much change in their behavior, but their attitude has changed dramatically. They are more realistic. They are more concrete. They are more searching in seeking for answers. It's for them a daily urgent matter. And as Dr. Glass indicated, there is an enormous gap between them and their parents on this issue. The parents are concerned mainly about future and responsibility. They are either unaware that this represents a daily problem for the adolescent, or they are denying the immediacy and the urgency of it.

To illustrate this, I'd like to tell you a little about a talk I gave. When I was asked to give this talk to 100 teen-agers, grades nine through twelve, I was kind of worried that they might distort it in reporting to their parents, that I might be run out of town on a rail. Nevertheless, I decided to give it.

There were three talks, each one accompanied by a film. The first film was on anatomy and physiology, the second on the emotional aspects of sex, and the third on the religious approach to sex. In order to reassure the parents, a session was held with them first at which they were shown the film on anatomy and physiology. The minister asked me to attend, which I did.

I knew very well that the parents weren't particularly concerned about the religious attitude toward sex. What they wanted to know was what I was going to say to the teen-agers. I told them that when parents talk about this subject, they always stress responsibility; when kids talk about it, they talk about fun. What I'm going to say is that somewhere the two have to come together.

As a preparation for the talk, the adolescents submitted questions that they wanted answered. These questions, compared to the parents' anxiety about the future, revealed the enormous gap between the two. They also illustrated this ever-recurring human dilemma about sex. Here are a few examples.

The first one was from a 12th-grade girl. She was taking a rather intellectual approach to the matter: "How do you tell your children about the birds and the bees? You see, my parents only asked me once if I was aware of sex. What could I say—yes? I just don't know how to explain such a complicated mixture of emotion to a child; but I suppose I won't have to worry. They'll probably teach it in school by that time."

And then the girl gets down to brass tacks and asks: "What is the surest method of contraception?"

The next question was surprisingly enough from another 12th-grader, a male, who must be somewhat on the immature side. It said: "Where do you start with a girl on a date?"

And another one, a 12th-grade male who obviously had some plans on his mind which were making him uneasy, said: "Is it really right to get a girl high just to have fun with her?"

And then we turn to a senior girl, who obviously differs with her boy friend: "If a boy says that I don't love him because I won't have intimate relations with him, could you explain that this isn't true (without bringing God into it)?"

The next girl, also a senior, revealed some anxiety about the strength of her sexual drive. She says: "Is there such a thing as oversexed in females? If so, what can you do about it? What can you do about having a feeling of 'wanting'?"

Another girl: "What's wrong with premarital sex? I need better reasons than I've heard so far. I've heard all the usual reasons. What about a girl who goes with a guy for about two years? You really like each other. You get along with other people so you don't limit yourself too much, but you still really like only him and he likes only you. You've even talked of marriage after you've finished college. How far can you go? What is wrong with premarital sex while you are juniors and seniors in college if your relationship has lasted that long, and if you don't want to marry until after college?"

Another girl approaches the subject intellectually: "How much of a part does sex play in a relationship with a boy? How much should it play with a boy you date steadily? With a boy you date occasionally?"

Now here's a girl who touches all the bases in her concern about sexual intercourse, its consequences for her, for the boy, for her parents: "Is it proper for a girl to go all the way with a boy if she's going steady with him at an age older than 16? What do parents think of the younger generation having premarital sex, especially of one of their own children? What is it that makes a boy become so emotional when he is having intercourse with a girl; what actually happens to the boy? Do girls have a problem of becoming too emotional during sexual intercourse with a boy? If so, how can she prevent this? If a boy starts to become too involved in sex (during the lovemaking) how can a girl make him stop, yet still remain on friendly terms as before without sex? What happens when a girl loses her virginity? At the time she actually loses it, can a boy tell?"

The next is from an 11th-grade boy who seems to be a very compliant fellow. He says: "If a girl likes sex a lot, should I give it to her?"

Here are two tenth-grade girls who are rather indignant over the whole affair: "How can something so natural be so highly restricted? The purpose we serve is to reproduce the human species. Why then, psychologically, do humans feel the need to build up this tremendous ritual?"

The last question is from a ninth-grade boy: "As silly as it seems, I would like to know if there is a special time that intercourse should be done. Obviously, when a girl has her period, but what time of day or night should it be done?"

Well, the questions illustrate what a tremendous, urgent, immediate, and practical problem it is.

Now the end of the story is that I gave the talk and I tried my best to answer the questions. And it was like dropping a stone into a bottomless well. To my knowledge not a single one of those 100 teen-agers said a word about it to their parents at all.

Now to pass on to where there is more change in behavior. It is seen in those in the mid-twenties who have passed their adolescent stage of sexual development and who have a more secure sense of sexual identity. Among them traditional sexual morality has given way to the following view: Sexual play is avoided if possible, unless the boy and girl really care about each other. If they do care, sexual play occurs as a preliminary to sexual intercourse, which itself is seen as important, but subordinate to a higher value, a close interpersonal relationship. They have replaced the ancient virtue of chastity with that of fidelity, meaning that a girl has no compunctions about having sexual intercourse with a boy with whom she is in love, but today would no more think of being promiscuous than her mother did 20 years ago—but for entirely different reasons.

A good example of this is seen in a college girl named Sally. She had not expected to engage in sexual relations in college. In her junior year, however, she met a boy who, she said, was interested in her interests and she in his. Eventually, they did have sexual intercourse. Here is her description of her feelings. "It got to the point

where it really got frustrating not doing it. We had been going out together seven or eight months and it seemed if you feel strongly about the other person and you really love him, I don't see anything wrong with it, because it is a complete relationship, as complete as for some people who are married. This is one action where you give everything you have to the other person. It would have been almost wrong to keep holding back something that I really wanted to give."

Certainly, some would be alarmed that this sort of change may lead to a decline in morality. However, this change does not seem to encourage orgies or lack of control, but rather a different kind of control, self-control, based not on guilt or fear of disapproval, but on a concept of human relations that emphasizes self-respect, human worth, and dignity. But what are the reasons for this change?

The prevailing standard of sexual morality originated 2,000 years ago under the aegis of the Roman Catholic Church, and this standard emphasized chastity, virginity, and the spiritual merit of denying the flesh. It is these very standards that are being challenged today. Is it not possible that these standards which have held sway for so many years may at the same time contain some inherent handicaps to human expression which the younger generation is no longer willing to accept? Therefore, may they not view their efforts to emancipate themselves from their heritage as evolutionary rather than revolutionary? The fact that the impact of religion has decreased and science has increased would support this theory that their efforts are revolutionary. The impact of religion has decreased and science has increased suggesting that the use of reason, rather than religion, has become the guide for the conduct of one's life.

Another reason for the change in sexual views has been the persuasive influence, I think, of the psychoanalytical view. It sees the failure to integrate sexual impulses and feelings into the personality in a healthy way as impairing to personality growth and producing emotional difficulties.

Finally, the demands of women have become increasingly strong for equality on all levels. They see the double standard as keeping them from enjoying the pleasures of lovemaking, which men enjoy without serious condemnation. This rebellion is not in the direction of curbing men, but rather toward releasing women. Further, development of the pill which has freed womankind from its ancient servitude to pregnancy, together with the efficacy of penicillin, which has minimized the danger of infection, have removed two common sources of both sexual anxiety and control; thereby allowing women more freedom.

You might well ask at this point what does all this have to do with an adolescent's sexual problems. His older brother and sister are carrying out the revolution, but he is the one who must come to grips with its effects. He must develop his sexual identity through interaction with his fellows in the sexual mores of his culture. Therefore, it is he who is confronted with the shifting sands of a changing sexual morality in the social sphere at a time in his life when, lacking a personal sense of sexual identity, he must wade through those shifting sands in order to find that identity. Although the changing social climate immeasurably complicates his development since it gives him few certainties upon which to rest, at the same time it may afford him the greater potential by giving him more freedom to explore to find that identity.

Now what are some of the implications of this revolution? Let us consider the advantages first, and then the hazards.

There are many adolescents who, excessively inhibited, come to a dangerously late period of their development before fully realizing they have sexual problems. The revolution may impel these to recognize and seek help for their problems earlier.

For example, I saw a 22-year-old girl, Jean, who was a senior at one of the better eastern girls' colleges. She sat in my office and hesitantly and tearfully told the following story.

She had always been popular with boys and she began dating at 14. Initially, she had reveled in her successes—proof of her femininity. When she first became involved with a boy at 16, she developed such severe anxiety, nausea, and vomiting on each date that her only recourse was to end the relationship. She allayed her fears with the thought that she would grow out of this difficulty, but time was to prove her wrong. The pattern was already set and it continued unabated through the next six years. She feels she must have dated at least a hundred boys in college, but every time one became close, the symptoms would resume and she would have to break it off. She had to settle for an endless line of superficial dating

because she didn't dare get into a close relationship with a boy.

I could not help wondering as I listened to this attractive but immature girl, that more pressure of the kind implied by the sexual revolution might have brought help for her sooner.

An 18-year-old college sophomore is another example. She had been having emotional difficulties since the onset of puberty when she became anxious, depressed, withdrew from her friends, and spent all of her time on schoolwork. It was necessary for her parents to send her away to a special school for treatment. Gradually, she improved and went on to finish high school and to enter college. She again became anxious and depressed and came to my office for treatment. Although she maintained an active social life with an average amount of dating, she had never had a close relationship with a boy or any sexual activity, neither of which was a source of concern to her. After a year of intensive treatments and much working through of her anxiety and depression, it became clear that she was terrified of her sexual feelings and impulses so that she avoided any occasion with boys that might provoke them. She had always been dimly aware that something was wrong with her, and without facing up to the fact, anticipated that she would grow up to be an old maid.

The summer of her freshman year, she took a cross-country trip with some girl friends and was amazed to find, when visiting a number of campuses throughout the midwest, that girls her age—see it only happens in the midwest—were living with boys. This confrontation with changing sexual standards brought home to her, in a profound way, her own sexual immaturity and motivated her to work on her sexual difficulties and treatment. Twenty years ago this girl's sexual difficulty might well have escaped notice, perhaps even to marriage.

On the other hand, certain risks may accompany this sexual revolution. It may precipitate a premature attempt at sexual relations, either by those who are immature and not ready for it, or by those who are over-inhibited and cannot accept the emotional consequences of their actions. Their efforts then become abortive, and can have disastrous consequences to their emotional life as suggested by the following example.

I saw an 18-year-old freshman in college who had come from a well-to-do Puerto Rican family. He was raised as a strict Catholic and attended private Catholic schools. His father, feeling that further religious guidance was necessary, encouraged him to attend an Ivy League school. Here, he was exposed for the first time to differing views about sexual behavior, and when he fell in love with a girl from another college they would rendezvous in New York city in a hotel bedroom, and they would spend the afternoon lying in bed necking. Driven by his impulses but unable to consummate them because of his conscience, he developed intolerable sexual tension which he later relieved by masturbation which, in turn, led to depression and feelings of inadequacy. In these depressions he would roam the streets of New York all night seeking solace. Overwhelmed by these feelings, he finally was unable to do his school work, so he dropped out of college, and was referred to me for treatment. It took many months for him to understand the conflict between his sexual impulses and his standards.

In conclusion, there are a few things we should remember about the management of sexual problems. Too often, we abandon our youngsters at this critical time of life to work out their problems by themselves. We afford them no easy channels of communication to check their thoughts and impulses without being criticized or reprimanded. I suspect we do this because, often as not, the emergence of their sexuality recalls to us the sexual problems that we encountered at that time of life and have spent a good many years trying to repress.

Instead, we adults should neither lecture nor admonish, but rather help our charges to understand the human complexities of sexual life. We should discuss directly and openly both the developmental and the social issues raised by their behavior. In all candor, we might suggest that sexual life has to be subordinated to the total well-being of the personality, as well as to human relationships, and that it, therefore, entails responsibility as well as the pursuit of pleasure. Indeed, the greatest pleasure can be found only when it is subordinated in this way.

And finally, perhaps we should keep in mind that the goal of our efforts should be to keep our patients' and our children's developmental pathway open to a healthy and mature adult sexual life, one that combines the utmost in pleasure with the necessary amount of responsibility, first to their own conscience, and then to their fellow human beings.

Addiction, Psychodelic Experimentation and Abuse of Drugs by the Concerned Generation

DALE G. FRIEND, MD
Assistant Professor of Medicine
Harvard Medical School
Boston, Massachusetts

Drug addiction appeared very early in the development of the human race. Poppy seeds have been found near the dwellings of primitive man, and we know natural products capable of causing addiction in man have been in use for centuries. No new substances present in nature in this category have been found, in spite of the extensive search. Plant products capable of exerting psychological effects have also been in use for centuries. However, there have been discoveries of new substances of this type in recent times, and there is good reason to believe that additional agents will be found. In this category, the very nature of the action of these drugs makes it difficult to develop a true assessment of their action. It is easy to be misled as to the effect on the patient, if any, and the type or pattern of their action. For example, claims made by certain groups, that smoking dried banana pulp or peels gives a psychological effect, are without foundation. Such could either be a delusion resulting from a placebo effect, or a hoax put on the squares by the hippies.

Although man has experimented with drug effects for centuries, there appears to be a new and perhaps a more ominous pattern emerging in recent years. In primitive societies, and probably through most of known human existence, drug use was confined to the older, more experienced members of society. Frequently, they were used in tribal rites. Now, for the first time, we are seeing the use of various drugs in young, inexperienced adolescents. Alcohol, marijuana, LSD (lysergic acid diethylamide), various solvents, and other agents are now being used in high school and even in junior high school groups.

Consequently, there is a great deal of misinformation and confusion concerning drug abuse. For many years, the scientific world made a distinction between what was considered drug addiction and drug habituation. This type of distinction really has no place in modern thinking, since investigators and people with knowledge in the field know that addiction can be a matter of psychological dependence as well as physiological dependence and may take place with a variety of substances, even those which are not known to possess any high degree of addicting propensity. Habit-forming narcotic drugs such as heroin, morphine, opium, meperidine, and derivatives of these substances have been a source of trouble to various civilizations through the centuries. At times, large segments of certain societies have been infected with addiction to these agents as, for example, China in the early eighteenth century following the Opium Wars. For the most part, however, addiction to narcotic drugs has not been widespread in modern civilizations. It has always been a source of worry, but society has constantly fought well enough so that it has been restricted to a very limited percentage of the population. For instance, in the early part of this century in the U. S. A., there was thought to be one addict to opium, or its derivatives, in every 400 people. This was a result of the widespread sale of narcotic-containing patent medicines. After the Harrison Narcotic Act went into effect the rate fell to one in 4,000. Even so, there is good evidence to indicate that the number involved is again increasing at the present time, both here and in England.

The Three General Categories

Clinically, the physician can divide addicts into three general categories. First, there are the socio-economically deprived individuals who become addicted through ignorance and the bad influences around them, where they are subjected to companions who are involved in the addiction rackets, and carefully led into the addiction by pushers who make supplies available until they are hooked. Then they are no longer able to resist the effects of the drug, and become victims of the rackets that control the addicting drug market. Oftentimes, these individuals are not only socially and economically deprived, but they are individuals of races which have been discriminated against. Usually, they come from broken homes, and a great many of them have severe psychological conflicts created by their surroundings, their station in life. These factors, and various others, have operated to put them into a situation where they do not feel that they are in the main stream of life. They have deep resentments, severe mental suffering and a sense of hopelessness that makes them mentally receptive to the peculiar euphoric effect of narcotic drugs. In other words, it seems to these individuals that the solution to their suffering, both mental and sociological, is the relief afforded by the drug. They substitute an unreal world of drug euphoria for the real world which, in many cases, they feel has rejected them. It is precisely with this group with unsolved emotional and sociological problems that narcotic addiction has gained such footholds. It is these individuals that present serious problems in treatment.

A second group are those who become addicted through medical accident. These are individuals who have a stable position in society, and who have no need for any artificial substitution for emotional stresses. They become addicted because of the pharmacological effects of the drug. They are patients who have suffered some debilitating illness associated with considerable pain and have been given narcotic drugs for the relief of their pain. Some time after a period of two or three weeks, the patient becomes physiologically dependent on the drug because the initial cause of the pain, which may by now have ameliorated, is mistaken for the pain of addiction withdrawal. The patient and, oftentimes, the physician are not aware that this is taking place. It is only after a period of several weeks when there is no obvious pathological or physiological reason for the pain, that the physician realizes that the pain now is that of withdrawal. When this situation is recognized, and the patient and physician take proper measures to withdraw the patient, these individ-

uals almost always get well. However, they must be handled properly. They need firm guidance for a period of time until the damage done by the physiological dependence has been entirely eradicated.

Finally, there seems to be a third group of individuals who on the surface appear to have no real emotional or sociological conflicts, but who, as a result of experimentation or during temporary stress, take narcotic drugs until they develop a physiological dependence. They then use the drug to mask the difficulty of facing up to life's problems. Frequently, these individuals are most difficult to manage. They tend to return to addiction very much like the first group, although there is less overt reason for them to do so, since there are more factors working to benefit them than in the first group. All too often, patients in this category are likely to be intellectuals or professionals such as, physicians, nurses, and pharmacists.

Another useful way to classify narcotic addicts is to consider the psychological and emotional make-up of the individual. In the first division are those with inadequate personalities. These are the passive, dependent, demanding patients who expect society to take care of them. They are self-centered, immature, and cannot solve life's problems. These individuals use narcotics as a prescription for their anxiety and frustration.

Contrary to the first group are the hypomaniacs. They have high energy levels, causing physical overexertion, together with unrealistic aspirational goals. This leads to frustration and failure, since this type of person must continually win approval of others. As a result, he accelerates his activity until he is under serious pressure. Then he takes drugs to slow down and to relieve the pressure. Narcotics inhibit his self-critical faculty, and insulate him from reality.

This next group is also characterized by extreme self-criticism and depression. This attitude makes him fearful of mistakes, so that he underacts when frustrated. In seeking oblivion, drug addiction allows him to feel normal since he is less critical. However, use of drugs, in turn, makes him feel more helpless and can lead to overdose and death.

Finally, there is the cyclical addict who goes from one extreme to the other—from hypomania to hypodepression. Correspondingly, his mood fluctuates between aggression and dependency. Various drugs are used, depending on mood, from amphetamines to narcotics.

The Effects of Narcotics

Narcotic drugs will affect every living tissue. Individuals exposed to the effect of addicting drugs for periods of a few days to several weeks almost invariably develop a physiological dependence. Although the basis of this dependence has never been thoroughly explained, we do know it is not entirely psychological: Tissues grown in tissue culture and gradually exposed to the effect of narcotic drugs, ultimately incorporated some effect from the narcotic drug into their growth pattern, so that they died unless the drug was supplied. Thus, some fundamental change has taken place in the cells exposed to these agents. The cell has developed a disorder which demands that it receive the drug, or injury to the cell will occur. In light of what we know about the action of certain chemicals, which affect enzymatic activity and liver cell's microsomes, whereby they become more effective in metabolizing certain substrates, it is certainly within the realm of possibility that addicting drugs may in some way influence these processes. This, in turn, may be harmful to the cell itself, or cause it to form certain metabolites which affect the cell.

There is another interesting aspect of addiction to drugs, whether it be alcohol, barbiturates, or narcotics, which gives many of us cause for concern. It is now known that most drugs readily pass the placental barrier and reach the developing embryo in the uterus. This causes addiction in the fetus so that upon delivery, the infant, no longer receiving his supply of the narcotic, develops severe withdrawal symptoms. For a few days after birth, a very uncomfortable period occurs until the infant has been weaned from the narcotic he received from his mother's blood. Presumably, these children, once withdrawn, progress normally. Whether this is really the case is of concern since cells thus exposed to narcotic action may well have developed changes in their structure or function. In this case, when the cells are exposed to even small amounts of a narcotic, they may, because of their previous sensitization, become easily affected thereby leading the individual into addiction once again. This reasoning might be extended even further in the case of pregnant mothers who drink alcoholic beverages, take barbiturates and other drugs. Possibly, the use of such drugs may sensitize the developing brain cells in the embryo, so that after birth, there

is a period of restlessness. However, no one pays much attention to it, and passes off an inability to sleep, excessive crying, and other manifestations of a mild withdrawal syndrome as part of the normal pattern of any new-born infant. Consequently, when the child grows into young adulthood where he again meets the old sensitizing drug, whether it be alcohol, barbiturates, or narcotics, he immediately develops a craving for the drug which rapidly leads him into alcoholism, barbiturate or narcotic addiction. Those of us who have taken careful note of alcoholic patients find that some of the most severe cases we have seen are individuals whose mothers were also chronic imbibers of alcohol. A great deal more information should be obtained in this respect, since prevention of cell sensitization may be a very important aspect in preventing addiction to various types of drugs.

Methadone Management

The withdrawal of patients addicted to the narcotic drugs is not very complicated. With the weak products that are available on the market today, withdrawal is not often a very serious problem. For example, the street heroin used to contain 50% heroin, but now the average sample contains about 6%. There are probably two reasons for this: One is the powerful and effective drive by narcotic agents to prevent its entry into the country and their success in seizing huge amounts of it from time to time. The second reason is probably the greed of the racketeers who stretch it as far as they can to increase their profits. For those who have been exposed to large doses of narcotic drugs, the most satisfactory form of withdrawal is hospitalization, and a substitution of 1 mg methadone for each 4 mg of morphine or heroin, or 10 mg of meperidine. Over a period of about ten days this dosage is rapidly reduced. If the patient becomes restless, the use of chlordiazepoxide in large doses in the order of 50 or 100 mg or more daily, can be used to aid the recovery. Once the patient is completely off the narcotic drug, it is extremely important to set up a very careful rehabilitation program.

In general, if the socio-economic situation can be improved, it will have an important bearing on the recovery of the individual. There must be a careful follow-up with 24-hour supervision on the part of family, friends, or groups, for many months after the drug has been withdrawn. Usually, an interested husband or wife, brother or sister, is able to accomplish more than social workers, psychiatrists, or physicians. It must be remembered by everybody concerned that the patient is extremely vulnerable. He has no will power to reject the efforts of pushers. Even the slightest emotional disturbance will cause him to become restless and lead him rapidly back into addiction. Therefore, someone must "baby-sit" with the patient continually to prevent these sudden urges to return to the previous addiction. In recent years, several organizations have sprung up which tend to afford this type of supervision, and for the most part, they have been valuable in helping the dependent addict.

Presently, there is considerable interest in a program of substituting methadone in very large doses to control the addiction craving of the former narcotic addict. In the hands of very devoted interested workers, there seems to be a reasonable degree of success with this program. However, many feel that this is substituting a weak narcotic for a stronger one, and is really hindering a satisfactory cure of the individual. As noted by many observers, if the addict can learn to live with his addiction by never increasing his dosage to obtain euphoria and by taking just the amount he needs to prevent the severe pangs of withdrawal, he can live for years in this situation while carrying on a useful occupation, and, on the whole, being adjusted reasonably well to society. Therefore, many suspect that this is what is happening in the methadone program, and from past experiences it is known to be reasonably effective.

Undoubtedly, there is need for considerable improvement in the management of addicted individuals. Certainly, those in socio-economically deprived areas should be, if at all possible, removed from these areas, retrained, rehabilitated, and reestablished in useful, productive jobs in areas where contact with narcotics would be almost impossible.

Barbiturates, amphetamines, and meprobamates are also addicting drugs. Usually, dependence develops after these drugs have been abused severely. Large doses, in the order of four to six times the usual dosage, given over long periods of time, are usually the cause. Since withdrawal can be dangerous—leading to agitation or convulsions—the patient is locked to the drug until competent medical help can be given. Abuse of these drugs leads to serious deterioration—mentally and physically. Usually withdrawal can be accomplished without much distress by gradually reducing the dosage: Use of a tranquilizer such as chlordiazepoxide and

the anticonvulsant, diphenylhydantoin, is helpful. Complete cure is, at times, most difficult because of the underlying personality.

On the other hand, individuals can become addicted psychologically to alcohol, tobacco, propoxyphene and a host of other such things. Although addicts of this type can be withdrawn successfully, the initial reason for their drug abuse presents the greatest problem. In this regard, I am reminded of a parody on an ancient quote, "We have met the enemy and they are us." Likewise, the drug is withdrawn, the patient does not like what he sees. His emotional instability or psychological aberrations led to the drug abuse in the beginning. It is the real problem, and, unless it can be resolved, permanent cure is not likely. Nevertheless, with skillful guidance, effective persuasion, education, and development of a new interest and outlook, the majority of these individuals do succeed.

Hallucinogens

In contrast to the previous drugs are the hallucinogens. The principal ones at the present time are: LSD, and its derivatives such as, lysergic acid monoethylamide—the active principle of the seeds of the Mexican morning glory which is about 5% as potent as LSD—mescaline from the Mexican cactus, myristicene from nutmeg, psilocybin from the toxic mushroom of psilocybe mexicana and its active principle psylocin, dimethyltryptamine, marijuana and N,α-dimethylphene thylamine (methamphetamine), and more recently STP (2, 5-dimethoxy-4-methyl-amphetamine) specially processed petroleum (it makes your engine run better). These have been introduced as drugs which bring about severe hallucinogenic, mind-altering properties. Sniffers use many agents from highly volatile solvents such as the toluenes to even gasoline.

Drugs in this category have created an unusual amount of attention in recent years, and certainly have provoked much controversy. They are, at present, a serious problem, challenging both society and medical science. All of these drugs are capable of producing various degrees of hallucinogenic distress. Their use, like that of the narcotics arose in antiquity. It is said that the Vikings worked themselves into a war-like mood by munching on the poisonous mushroom, Amanita Muscaria, and these same mushrooms, as well as mescaline, were used in the religious ceremonies of the Aztecs. Even today, members of the Native American Church use mescaline in their rites. The use of marijuana as hashish is also ancient. It is said to have been a tool in the hands of the hashishins. This word meaning takers of hashish gave origin to the term assassin, signifying one who took hashish to induce ecstatic visions of paradise before he set out to face martyrdom while performing a treacherous murder.

The effect of LSD was discovered accidently by Alfred Hoffman, a Swiss chemist, in 1943, when he tasted some of it. The drug had been synthesized in 1938 by Stoll and Hoffman in the course of their work on ergot derivatives. It is the most potent of the hallucinogens. A dosage of 75 to 150 micrograms will give a hallucinogenic effect. Doses of 1.0 mg have been used with a serious disruption of mental processes. Conversely, mescaline is given in a dose of 200 to 400 mg to induce the usual effect. Psylocybin requires a dose on the order of 10-20 mg for proper action.

A comparatively recent source of central nervous system stimulants are the amphetamines. They were first synthesized in the 1930's by Alles, who was trying to make a cheaper substitute for 1-α (1-methylaminoethyl) benzyl alcohol (ephedrine). Methyl amphetamine was prepared by Japanese chemists and used by them as an antisoporific in World War II. Subsequently, many derivatives of amphetamine have been synthesized. Racemic amphetamine, its dextrorotary component, and methamphetamine are widely used in a variety of situations, many of which led to severe abuse, such as auto and truck drivers using them to stay awake to drive longer distances, housewives getting a lift while reducing, students using them to keep awake to study more, and now hippies, meth heads, and speed freaks. The latter may inject 50 to 100 times the usual dosage of methamphetamine.

Originally, hallucinogenic properties of the hemp were obtained by eating a small amount of hashish, whereas now, it is more popular to smoke the powder prepared from the tops and leaves of the female plant. This is three to four times more potent than taking it by mouth. The exact dose is not known, but ⅔ of a cigarette or 1 to 4 gm of dried powder will give hallucinations.

It must be remembered our present day situation concerning the use of hallucinogens is not unique. We need only to recall the ether parties of the early 19th century where young people would assemble to sniff ether and have a hilarious

time. Out of these parties, knowledge of ether effects grew which culminated in its introduction into medicine by William Morton in 1846. Likewise, nitrous oxide, first known as "laughing gas," was used in similar circumstances. Inhalation was widespread, and such outstanding scientists as Humphrey Davies experimented with it. It was he who, going under the influence of nitrous oxide, suddenly thought that he had the secret of the universe. He immediately asked for pencil and paper so he could write the most profound message. Upon awakening, he eagerly sought the paper only to find that he had written, "Gad, the stench is awful." It is highly probable that much of the so-called "mind stretching," so widely acclaimed by some users of hallucinogenic drugs will end up with just about as much relevance.

The hallucinogens, except for bufotensin and dimethyltryptamine are readily absorbed from the gastrointestinal tract. For example, LSD appears in the blood extensively bound to plasma proteins. It does not seem to have an affinity for any special site, and only low concentrations are found in the brain. Its psychological effects, depending on the dose, may persist from 6 to 12 hours. Mescaline, though, is found concentrated in the kidney, liver, and spleen, it is mainly excreted unchanged in the urine. Up to 90% of a given dose can be recovered. Similarly, a high concentration of psilocybin is found in the kidneys and liver, and there is no accumulation in the brain. These drugs generally affect the peripheral autonomic nervous system as well as the central nervous system. Reactions to hallucinogens simulate an overstimulation of the sympathetic portion of the autonomic nervous system: the pupils dilate, the heart rate increases, and there is a rise in systolic and diastolic arterial blood pressure. There may also be some increase in blood glucose level, and there is commonly an increase in spinal reflexes, such as, the knee jerk.

The psychic effects are most significant as far as the central nervous system and the mental functioning are concerned. There is distortion of sense perception: vision becomes altered; there are hallucinations; dream-like thoughts occur; dream images appear; and there is a depersonalization of the individual. The emotional reaction usually present, varies from a euphoric sense of well-being, great pleasure, and excitement to the opposite extreme of anxiety and depression, the mood changing frequently during the periods of intoxication. The kind of reaction is influenced considerably by the environment, the personality of the individual, and the dosage of the drug. As to the mechanism of action in the central nervous system, very little is known. It is thought that there might possibly be some effect on neuro transmitters such as, epinephrine, norepinephrine, serotonin, acetylcholine or even histamine.

Although these drugs have been in use for many centuries, there is still no real consensus of opinion as to how important an effect they may have on the individual using them for any length of time. Certainly, enough evidence has been obtained now to know that LSD does produce very serious disturbances in the individual. It has led to severe changes in personality structures, emotional confusion, and deterioration. In addition, even weeks or months after the use of the drug has been discontinued, there is a re-entry of the hallucinogenic effect. Reports from large city hospitals such as, the Bellevue Hospital in New York, indicate that there are a good number of individuals turning up with acute psychoses resulting from the unsupervised use of LSD. These individuals have overwhelming fear, uncontrolled violent urges, strong hallucinations, which have led to homicide, and in certain instances have required prolonged periods of hospitalization for treatment.

Treatment consists of using a phenothiazine in adequate dosage to bring about as calming a state as possible, and to reassure the individual, who may be very sensitive and feel that he is in a hostile environment and subject to possible personal injury, even though such does not have any basis in fact.

Marijuana

Marijuana or "pot" is one of the oldest of the psychopharmacological agents, and one that is now most extensively used in modern day youthful society. This agent now smoked as a cigarette, which makes it more potent, was formerly taken in the form of a sweetmeat as hashish. Eating hashish was popular around the middle of the nineteenth century. In the avant garde society, such as occurred in Paris at that time, groups met to eat the drug. Charles Baudelaire, the French translator of Poe, was a very active member of such a group which met at the Hotel Pimodan. His description of the effects which are revealed in his book, *des Paradis Artificiel,* are classic. He described three stages of drug action. The initial phase was hilarity—uncontrollable laughter, giggling, even the most mundane action becoming a subject of great mirth to the intoxicated. This

phase was followed by an extremely increased sensitivity of sight, hearing, touch, and smell, gradually emerging into hallucination. This was followed by sleep, then the next day fatigue, emotional instability, inability to apply oneself, and a severe hangover.

Unfortunately, there is not much accurate data about the dose or the pharmacological action, in spite of its long use by millions of people. In comparison to LSD, marijuana is rather weak. There may occur all the aspects of the LSD action: hilarity, flight of ideas, weakness, increased hearing, heightened visual sensibility, visual and auditory hallucinations, and a disturbed sense of time. There is also an alteration of sensation. For example, the individual may feel that all the flesh has dropped away from his body and that he seems to be walking on his bones. The distortion of time and other senses may also lead to very pleasant hallucinations of vivid colors, and many types and patterns of color and forms. On the other hand, such distortions can bring about a very frightening anxious state in the individual who feels that he is losing contact with reality. This may profoundly affect his emotional structure so that he has a dreadful period of time until the effects of the drug wear off.

Amphetamines

The most dangerous of the recently introduced drugs are the amphetamines, especially methamphetamine and 2, 5 dimethoxy-4-methyl amphetamine (STP). These produce extreme overaction, euphoria, tremors—all the signs of sympathetic overactivity and intoxication—which can lead to extreme elevation of blood pressure, tachycardia and a shock-like state requiring enormous doses of phenothiazines to counteract the effect. The chronic user of the amphetamines may become psychotic, hyperalert, have all the auditory and visual hallucinations, and the tremors which are a hallmark of the action of these drugs.

Glue sniffers are a special problem. Usually adolescent boys apparently cannot resist the tendency to use various solvents for the peculiar euphoria they seem to create. Reports of serious brain damage from this practice are not unique.

The problems presented by the hallucinogenic drugs are considerably different from those of the addicting drugs. These agents, for the most part, do not produce physiological dependence or withdrawal symptoms. They may, however, lead the patient to psychological dependence in that they become a way of life, by helping the patient adjust to underlying emotional tensions or as a means of dulling, changing, or creating an excited sensory state, avoiding social, emotional or other conflicts which may be painful to the individual. They also serve as a means of exhibiting rebellion against parents, authority and society in general. Evidence of this is seen in the hippy movement.

Although some of us are shocked at this movement and the present day behavior of a certain segment of our youth, we should not be. Such signs of rebellion against established society have been with us since ancient times. It has been traced to ancient Egypt. Even Socrates expressed concern about the young men of Athens—their long hair, indolence, disdain for adult values, etc.!! Every century has seen such outbreaks, but as history proves, not all was lost, and the youth as they matured, faced the problems of their day and age as will our youth today.

In talking to the hippies as a member of the Governor's Commission on Drug Abuse, one is struck by the apparent unreality of the situation. Here were highly intelligent youths capable of discussing political, scientific, ethical and moral issues with a high order of significance. But on the surface they were dirty, wore dirty ragged clothing, lived in filthy quarters and seemingly had rejected most of the things our society considers necessary. They admitted they were users of LSD, marijuana and amphetamines but denied need or use of narcotic drugs. They divided drugs into two categories: problem and non-problem drugs. They consider heroin and opium derivatives problem drugs and claim they seldom use them. LSD, marijuana, and the amphetamines, with perhaps the exception of methyl amphetamine, are not problem drugs. They vehemently condemn a society that permits tobacco and alcohol to be advertised while on the other hand, makes such restrictive laws against drugs such as marijuana, which they consider rather harmless.

What is the Answer to Controlling the Spread of Drug Use?

Having interviewed the judiciary, it is apparent that drug abuse problems, already extensive, are spreading. Furthermore, it is involving younger and younger segments of the population. The judges discussed the difficulty in handling these

cases. They said that time and again an unkempt youth, obviously under the influence of a drug, would appear in their courts with all the evidence available. They would sentence him. There would be an appeal, but when the case came to the next court, an entirely different situation would arise. The youth would be clean and alert, presenting a paragon of virtue which would make the next judge wonder what was going on in the first court. This situation, to say the least, is frustrating.

Yet many have expressed fear about the severe penalties for the illegal possession of drugs. After an interview with the Judiciary of the Commonwealth, it was reassuring to know that jurists are careful to use the available laws wisely. Obvious first offenders with a few cigarettes were given suspended sentences or released with a warning. The Federal Bureau of Narcotics report for 1966 shows that of the marijuana violators 70% had prior felony convictions. The average age was 29 years. Only 21% of all convictions were for illegal possession. Only 3% were students, and only one-third of these or 0.8% were indicted for illegal possession. The data leads to the conclusion that the typical violator is a professional criminal nearly 30 years of age engaged in lucrative, illicit drug traffic.

What is the remedy for this situation? First, I believe education is imperative. All youth should know the facts about drugs. The widespread publicity about the harmful effects of LSD has led to a marked reduction in its use, and in time, it will probably be used only occasionally by the far-out individual and by controlled scientific studies for any possible benefits it may have in therapy. Its use now is thought to be less than 5% and about 1% or even less among college students. Although narcotics and other addicting drugs will continue to be a problem they will probably taper off in spite of the current increase in the use of heroin. There will continue to be a few barbiturate and other sedative drugs and amphetamine addicts, but the new laws restricting their sale will prove helpful here.

The future of marijuana is at present uncertain. It is not addicting, but it has properties that make it undesirable. Its use is spreading. It is estimated that at least 30%-40% of the youth in large eastern colleges have used it. Eighty percent have used it only once. About 15% use it during week-ends only, and less than 5% use it to solve emotional problems. It, like most fads, will probably begin to fade as youth becomes interested in other things. Like alcohol and tobacco, it is harmful to society. Alcohol, however, tends to make the subject more extroverted while marijuana tends to make him introverted. This property may, in the end, prove to be the factor that limits its use since our society, unlike certain eastern cultures, is extroverted, and, on the whole, is uncomfortable or impatient with introverted behavior. In other words, as one youngster said, "Who is intereseted in sitting in a corner and seeing pretty colored bubbles when there are so many things requiring action?" As to permanent harm, there will surely be some especially in unstable individuals where a latent psychotic pattern may become aroused or when the drug is substituted for their inability to contend with the problems of life. Firm and just laws administered with wisdom will surely see us through these trying times.

Despite the fact that depression has been recognized for over two thousand years and is the psychiatric diagnosis most frequently made today, there is much about it that remains enigmatic. Paradoxically, although we are still not sure of its cause, it is eminently treatable today. Nevertheless, the disorder continues to be a major health problem; its sufferers number in the millions. It is probable that it has altered the course of millions of lives, and even influenced human destiny. One of its sequels, a constant danger, is suicide. The suicide rate, which is one in ten thousand in the general population, is fifty times higher among depressed persons. All of these facts taken together indicate that it would be well for the physician to know something about this enigma, and its protean manifestations.

Depression in Adolescents and College Students

FRANCIS J. BRACELAND, MD
Senior Consultant
The Institute of Living
Hartford, Connecticut

DANA L. FARNSWORTH, MD
Director, University Health Service
Henry K. Oliver Professor of Hygiene
Harvard University
Cambridge, Massachusetts

When we say that the course of human affairs has been altered at times by depression, this is not hyperbole. It is known that earthquakes, floods, and other calamities have altered human destiny, but it is not as well known that destiny has been altered much more frequently by human emotions. The grandiosity produced by syphilis of the brain, the shallow and erratic emotional states accompanying schizophrenia, or the memory loss and emotional deterioration of cerebral arteriosclerosis, are recognized sooner or later because of the obviously abnormal thinking which accompanies them. There are striking instances in which each of these illnesses has tipped some dramatic national or international event one way or the other.

Due to depression, favorable enterprises have been abandoned because the owner had forebodings of disaster. Important research has been neglected because the investigator imagined difficulties which were not there. Defeat has been

snatched from the jaws of victory because a military commander countermanded a campaign which, in reality, had already succeeded. At a more mundane level, the housewife is too tired to maintain pride in herself or her home; the bright young man with high potential lacks the drive to convert his assets into successful accomplishment. The illness has many more paradoxes. The rich man feels he is poor; the beauty begs for plastic surgery; and depressed people in general are swayed neither by objective evidence, nor by logic.

What is this disorder which causes so much unhappiness? Is it an illness? How is it described, from whence comes it, and what can we do about it? There are many other questions. Is depression a well-defined clinical entity, or is it an exaggeration of mood? Is it quantitatively and qualitatively different from the normal mood, or is it a wastebasket in which diverse, poorly understood disorders are collected? Seemingly, it can be all of these things. Varying degrees and gradations of depression are described, from transient attacks of the "blues," through longer lasting mood changes and symptoms, to graver situations of distressing emotional and mental illness. As the term *depression* is used in everyday life, it implies lowered spirits, feelings of dejection, and a depressive unhappy mood.

The psychiatrist conceives of depression as a disorder characterized by varying qualitative deviations from the behavioral and experiential norm. He may refer to depression as a symptom, in which case he means anguish—a sad, dejected mood. Or he may refer to depression as a syndrome which comprises, in addition to the depressed affect, underactivity, loss of appetite, suicidal ruminations, feelings of hopelessness, insomnia, and other symptoms of a lowered mood disorder. The clinician may go even further and speak of manic depressive disorder or involutional depression, thus referring to the diagnosis of psychotic illness.

All people feel sad, depressed, blue, or melancholy at one time or another. Sometimes the cause is apparent and rational; at other times the emotion seems to "arise from nowhere" and sweeps over the individual in an inexplicable mood of "blackest midnight born". Occasionally, this depressive mood passes as whimsically as it came, and yet again, it seizes upon the individual and cuts him off from activity, from pleasure, and even from his fellow men.

The term *melancholia,* which is one of the great words of medicine and psychiatry, is of ancient origin. It is a relic of ancient influence, dating from the time that depressive spirits were considered to be due to disorders of the bile. In Greek and Roman medicine it was thought that the disease had its origin in an imbalance among body fluids, or humors. The ideal man was one in whom the four humors were mixed in correct proportions. In cases where black bile (melana chole), a supposed product of the spleen, predominated, it gave rise to a melancholy nature. Each nature was thought to be influenced by a planet corresponding to its dominant humor. Legend had it that the soul on its way to earth would receive gifts from the planets as it passed them. Saturn, the coldest, slowest, and farthest from the earth—the evil spirit of the earth's depths—was the patron of the melancholy. Hence, the terms *splenic, saturnine, bilious,* etc. became associated with the melancholic individual.

The first clinical description of the disorder was given by Hippocrates in the fourth century B.C. Aretaeus and Plutarch gave vivid accounts of the disorder, and the cardinal signs of the illness, as delineated today, compare to the descriptions given by these ancients.

The Specific Depressive Reactions

Aristotle once asked the question: Why is it that all outstanding men, no matter how they have distinguished themselves, are obvious melancholics? This question is quite important to us, for it indicates that the term *melancholy* has always had several meanings. On the one hand it describes an illness which disables a man and renders him ineffectual, and on the other hand it describes a quality which seemingly is part of a spiritually creative nature. It is obvious that these last mentioned persons are not sick, nor are they ineffectual. Somberness is their way of life and they have come to terms with it.

What types of depression might adolescents and college students fall heir to, in addition to the above? Well, when an individual becomes psychotic, and the psychosis is distinguished by a depressive mood attributable to some experience, and he has no previous history of repeated depressions, we might say he simply had a *psychotic depressive reaction.* This is differentiated from a *depressive neurosis* by the fact that patients with the latter illness have no impairment of functional adequacy and are not psychotic. If they have repeated depressive episodes, then we must think of *manic depressive psychosis.*

The main signs of depression are generally, but not always, obvious. They consist of a low mood, a loss of interest, a criticism of self or self-debasement, a general slowing up or agitation, varying vague physical complaints, loss of appetite, constipation, fleeting pains, and general bodily symptoms of an overall dejection. Along with this, there is a noticeable loss of zest, lack of interest in things which formerly were attractive, loss of the desire to live, and suicidal ruminations. (It should be remembered that depressions may be hidden under a weltering of physical complaints for which no satisfying underlying disease process can be found.) There is a general slowing up of intellectual processes accompanying the dejected mood, and a slowing up of motor activity. The illness is characterized by withdrawal from previous interests and even from loved ones, yet, there is a regressive action noticeable with increased dependency. Some of the depressive thoughts may become delusional as the individual becomes more indecisive, pessimistic, and vacillating, and he presents a sorry picture as sleep and metabolic functions get progressively out of order.

Briefly, it may be said that these patients are narcissistic and egocentric with many early infantile drives still active. The depressed personality is at the mercy of an extremely severe superego, and is usually overconscientious, overserious, complaining to the point of being subservient, obsessive, and on occasion, overly agreeable. The patient is invariably an individual who finds recognition of his own hostility entirely too threatening to his own security; he cannot allow a vestige of it to appear. He reacts by clamping down too hard and too quickly on any impulse which might in the slightest way betray aggressiveness, and thus he moves along under an unrelaxing constraint from which he eventually begins to suffer feelings of depression.

Some observers see three personality groups most commonly associated with depression. The first react to their hostile, aggressive impulses by an overserious, somber, overstudious, over conscientious pattern of behavior. This pattern, while it aids in the repression of impulses, also depresses the spirits. The second group has developed traits which deny hostility and utilize reaction formation, ie, the unconscious adoption of behavior that reflects impulses opposite to those which the individual is attempting to disown. They are the overly complaining, overly polite, subservient and obsequious types. The third group employs obsessive-compulsive habits (repetitive thoughts or acts provoked by unconscious urges such as, meticulousness, rigidity of behavior, and parsimony) in order to master these impulses. Attempts to desist from this behavior usually result in a vague anxiety and agitation.

Adolescence and Stress

Thus far is the background of the illness. Now consider the person who is to have it—the adolescent, the college student; for as in all of medical practice, it matters as much who has the disease as it does the disease he has.

Adolescence can be defined in various ways. Physiologically, its onset coincides with that of puberty; its conclusion, which cannot be clearly defined, varies among individuals. Emotionally, it is marked by the awakening of sexual curiosity and an intense drive toward independence, and it is completed when psychological maturity resolves the disharmony caused by disordered drives and reason establishes a hierarchy of values.

In the period of adolescence, according to Erikson, the major task is achievement of identity. If this task is not achieved, the result is negative identity. In this stage the person is like a trapeze artist: There is one moment when he is suspended in air—he has left a point of safety and has not yet reached another. What the individual has learned to see in himself must now coincide with the expectations and recognition which others bestow upon him. This is, or should be, the concluding stage of childhood. He subordinates his childhood to new identifications; he no longer looks to the past; the future can no longer be postponed. He searches for a slot reserved for himself in the scheme of things; he must have a clear picture of himself operating within, and belonging to a group.

Adolescents are involved in a struggle with parents and other adults, a struggle whose causes are real when adults fail to allow the adolescents to mature naturally, and when the adolescent fights for things which are already his simply because he is psychologically compelled to do battle. Youth must struggle to be emancipated from both the adult restrictions which might stunt their maturation, and the human tendency to remain secure and maintain the comfort of the known. In this struggle, which is partly with himself and partly with his environment, the youth goes through adjustment phases which are typical in their occurrence and tentative in their outcome. If his patterns

of adjustment are healthy, they will satisfy certain needs. The adolescent must establish an identity which will give him solid ground on which to stand and meet life. Indeed, he must find out who he *is* while the scholastically and vocationally oriented adult world is demanding to know what he wants to *become*. This drive to formulate a personal identity is a core problem. The old affiliations are strained by the conflict between his new attitudes toward himself and others, and their old attitudes toward him. Outstriding and overreaching, he tramples on past relationships. He tends to rebel against all those who would tell him what to do because he confuses obedience with loss of selfhood.

His rebellion and quest for a new personal identity propel the teen-ager into collusion with his peers. Hair fashions, clothing fads, music manias, and dance crazes become for him signs and symbols of individuality, differentiating him from adults while for adults they seem to be exactly the opposite. Behind the masks, the teen-ager works with frenzy to achieve some genuine identity and individuality so that he need not continue to hide and protect himself in this manner. Adolescent styles sometimes shock adults; their fads are sometimes frightening. It is important to understand that they are not the goals of life, no matter how much they may seem to be; they are the means by which teen-agers attempt to achieve an identity.

Adults who fail to see beyond such behavior, the reasons for it, and the needs it may fulfill are usually critical, even though that behavior may be the adolescent's means for arriving at a healthy maturity. An adolescent who is not in conflict with adults at some time is probably not developing properly. Anna Freud, Erik Erikson, and others repeatedly point out that those "model" youths who have no authority conflicts usually have a greater potential for emotional problems than those youths who indulge in argument or antagonistic behavior from time to time.

The adolescent must also develop a sexual identity. An adult's sexual role is to a great extent determined by the sexual orientation of adolescence. During these years the young person is not only unfolding his sexual powers and activities, but is also establishing attitudes about them.

To develop a proper orientation for his masculinity, a teen-age boy needs a father or male figure who presents a healthy picture of what manhood is (a father who is neither a weak, ineffectual person nor a harsh, brutal man), and a mother who is secure enough in her own feminine role to be able to respect her husband's male position and not destroy him in their own relationship, especially in her son's eyes. The teen-age girl needs the same configuration for a proper sexual orientation. Her mother must present for her imitation a healthy and acceptable picture of what womanhood is. She must, therefore, be a psychologically approachable person who is neither aggressive and domineering, nor disenchanted with life in general and her life as a woman, in particular. Similarly, the adolescent girl's father must

Courtesy of the News American.



be sufficiently stable in his masculine role to respect the feminine role of his wife, and thus, implicity encourage his daughter's feminine identification.

We have been reviewing some of the normal conflicts which the adolescent must undergo if he is to reach maturity. Though it is a hazardous and treacherous route, it is the only one which can bring him to the open plains of adult life. The various ways in which adolescents deviate from that route, refuse to travel it, or exaggerate the difficulties encountered constitute the emotional problems and delinquent behavior which disturbed teen-agers manifest.

Everyone, in or out of college, must face stress and cope with it. The essential task of education is learning to overcome handicaps and to use one's abilities as effectively as possible. Certain background factors increase vulnerability to stress. Knowledge of them can decrease their influence and help develop effective methods of dealing with life situations.

Parental conflict or discord, particularly if disagreeing parents try to involve the children in their disputes. Divorce is no more traumatic than a constant state of tension ("cold war", some students call it) between the parents.

Marked contrasts in values between the home environment and those of the college, whether these concern religion, politics, unfair discrimination, or social customs.

Inadequate or improper role models—if the parents or other significant older persons in a child's life show little respect or enthusiasm for intellectual pursuits, he has little reason to do so.

Extreme permissiveness or rigidity or inconsistencies in discipline—without consistent discipline, a child does not know what to expect and can learn little from experience. As one preparatory school boy said to his psychiatrist, "My parents never tell me what to do. They never stop me from doing anything. I don't have freedom like the other boys have."

Improper or inadequate sexual education

Failure of parents to perceive children as separate individuals. Such parents think of their children as extensions of themselves.

Lack of meaning or purpose in what they have been doing. Their rebellion, desirable though it may be, is not always against any definite limits or standards.

Poor study habits—Not having been required to work up to, or near capacity, they don't try to achieve as much as they can.

Factors in College Accentuating Stress

When the young adult goes to college, stress and conflict are inevitable, even necessary, for rapid progress toward maturity. For many of them, it is their first extended period away from home. In the whirl of forces demanding consideration, influences toward developing a life of the mind *versus* anti-intellectual pressures from society and individuals about him, coupled with the necessity of developing appropriate independence and self-reliance, it is no wonder that the college student has difficulty in developing a set of standards and values that are satisfying to him. Students must often cope with such social pressures as, approval of "getting by" on a gentleman's C, strong emphasis on social activities, and many of the attitudes encountered in fraternities and sororities (where there may be more emphasis on grades, than on the learning they should represent).

College students have the usual personal tasks involved in giving up the habits of childhood and youth, while at the same time assuming the responsibilities of the mature adult. In a more rural and restricted environment, this was usually not a complicated process. There were relatively few choices open. One did as the society directed, though choice was possible within narrow limits.

Now all this is largely changed. Opportunities, good or bad, are almost limitless. Instead of certainty, students now face uncertainty. They have incurred the dilemma of choice. An old Dutch proverb clearly expresses the situation: "He who has a choice has a problem." Making a choice would be simple if it were not for the consequences. Each discipline is becoming increasingly complex year by year.

Unfortunately, many college students never have the opportunity to develop a meaningful relationship with any faculty member. An obstacle to more sophomore-teacher discussions is the distaste undergraduates feel for seeking advice. The problem is to get the sophomore talking, and listening patiently and supportively. If grown-ups will only listen, the sophomore will ultimately make good sense to himself.

Attendance at college has been said, by one observer, to be society's most elaborate device for

the artificial postponement of adulthood that could be imagined. But for the student the quandary becomes: "How can I remain effective, feel a sense of meaning and purpose, and yet not know precisely what I am preparing myself to do?"

Depressive Illness in College Students

Sometimes stress is too great, and many students have too few resources for coping with it, and develop serious and disabling emotional conflicts. But many of these conflicts can be treated successfully, and many of them could and should be prevented. Furthermore, recent changes in the social and cultural climate favor the development of a willingness and a capacity to recognize these problems. Recent statistics from college health services indicate that for every 10,000 students, 1,000 will have emotional conflicts of sufficient severity to warrant professional help; 300 to 400 will have feelings of depression severe enough to impair their efficiency; 100 to 200 will be apathetic and unable to organize their efforts—"I can't make myself want to work"; 20 to 50 will be so adversely affected by past family experiences that they will be unable to control their impulses; 5 to 20 will attempt suicide, and 1 to 3 will succeed; and 15 to 25 will become ill enough to require hospitalization.

Walters has recently described a cluster of symptoms which is very common among male college students, and which he refers to as *apathy*. It is expected that every student during the course of his college career will feel apathetic when the pressure of work and his own expectations become too great. There are some students, however, who respond to a transitory stress with prolonged apathy. Such students have a total disinclination to study. They appear to the college officials and to the psychiatrists as indifferent, languid, indolent, lethargic, dull, or apathetic. As one student expressed his plight: "I can't make myself want to study." Such students suffer reduced emotional stability, preoccupation with current work difficulties to the exclusion of past experiences and future expectations, and inability to study in spite of constant efforts. Such students describe themselves as being without feelings other than those of emptiness, physical lethargy, and intellectual impotence. In some colleges the syndrome is known as the "sophomore slump", though it may occur at all college grade levels. Such students, by reason of disturbances in previous interpersonal relations, frequently are compelled to present themselves as weak and inadequate. Their general concepts of competition are unrealistic; they are convinced that they would readily succeed if only they exerted enough effort. In all the case histories studied, there had been actual injury or failure of a successful parent, and to the student, success and competition represented potential personal disaster, similar to that experienced by the parent. It, therefore, became necessary to avoid success, and the unused potential provided a rationalization for the student's failure.

Apathy is a defense that protects the patient or those close to him from being hurt. By living out his fantasies of being deficient, the patient prevents himself from dealing with the effects of his own aggressiveness. His strong feelings of hostility and rage toward certain people are partly diverted to anger toward other persons, and partly inward to himself, producing guilt and "failure". By turning some of his strong feelings outward, seeming to promise success and then turning near-success into failure, the student torments and tantalizes those who help him until they, too, are reduced to a feeling of helplessness as great as that exhibited by the patient.

Apathy may be a precursor of depression, or it may be followed by neurotic symptoms. These patients have never allowed themselves to formulate clear goals, and are committed to nothing. In a sense, apathy is a continuation and an exaggeration of the defenses and solutions commonly used by the adolescent. Such patients have a prolonged adolescence because of unresolved conflicts centering around the formation of a mature identity.

Depression in Women Students.

Women students have many of the same problems as the men display. Suicidal gestures are not uncommon, and should always be taken seriously and investigated thoroughly. Sometimes they call for removal from college; sometimes not. Depression is a common symptom prevalent in young women. They may worry excessively and experience feelings of futility. Some of them use very inappropriate devices to cope with anxiety or depression: suicidal attempts, personal slovenliness, overeating, premature sexual experimentation and excessive and compulsive studying.

Suicide.

The danger which is always in the offing in depressive illnesses is suicide, and it must always

be kept in mind. When persons are going into a depression, and while they are emerging from a depressive illness, the danger of suicide is much greater than when they are in the depths of the illness. When they are deeply depressed, they are often unable to organize themselves sufficiently to carry out their intentions. In hospitalized patients, the greatest period of danger is on weekend leaves from the institution, or shortly after discharge from it. It is thought that the risk in the first six months after hospital release is three times greater than in the general population, and in the second six months, nine times greater.

Attention must be paid to all suicidal ideas; none can be dismissed lightly. Each threat is a call for help, and each one should be looked into thoroughly. Assuring oneself that "he won't do it", "he is a coward", "he has too much to live for", or "it's against his religion" is taking a chance on tragedy. If an individual is depressed enough and desperate enough and sees no future before him, or sees only ruination and disgrace in his path, he is definitely a suicidal risk, no matter who he is or what his belief or position might be.

Whenever a person contemplates suicide, thinks over methods of accomplishing it, considers ways to make the event look like an accident, or determines that the world and, especially his family, would be better off without him, it is obvious that he needs to be under expert care and, more likely than not, needs to be in a protected environment.

Treatment of Depression

Treatment of emotional disorders in adolescents follows the same modes as treatment of adults. For the great majority of adolescents, individual or group therapy brings them through that critical developmental stage in which feeling fuses with behavior, and the individual use of reason seems far distant. For those with severe problems, hospitalization, combined psychotherapy and drug therapy is the usual procedure. We should say at once that we have no "miracle" antidepressant drugs at hand, as yet. Nevertheless, the gain from the use of the drugs we do have is great, and by their usage, depressive attacks in many individuals are shortened, and many depressed patients are able to avoid hospitalization.

Two classes of antidepressive drugs, the so-called monoamine oxidase inhibitors (MAOI) and the tricyclic imipramine-like substances, are equally effective in the proportions 60%-70% of selected patients mentioned above. They also have the same time lag from beginning of treatment, to appearance of improvement—one to three weeks. The four MAO inhibitors in clinical use, which act by indirectly stimulating the central nervous system are iproniazid (Marsilid), isocarboxazid (Marplan), phenelzine sulfate (Nardil), and nialamide (Niamid). Unfortunately, Marsilid is now forbidden in this country because it was said that the side effects were too distressing. The tricyclic antidepressants which are in more common use are imipramine (Tofranil), desipramine (Pertofrane), amitriptyline (Elavil), and nortriptyline (Aventyl). The giving of these drugs and the handling of their side effects is an art.

It cannot be reiterated too often that the deeper and longer-lasting forms of depression are not matters to be trifled with. They require expert attention quickly. Sometimes it seems as though the person who is deeply depressed is more fortunate than the one who is mildly afflicted. The first gets attention and help because of his obvious symptoms, while the latter generally knows only that he feels badly but is not aware of the reason why. Because his symptoms are not so striking, help is slower in coming, and the distressed individual drags about unhappily trying this and that remedy hoping to get relief.

At the risk of being annoyingly repetitive, we need to remind everyone that the prognosis for depressive episodes is good, no matter what is done. The difficulty comes from the fact that the person suffers for so long while waiting to feel better. Therefore, intervention should be sought, both to allay suffering and to protect the patient from harming himself. One need not get depressed contemplating depression in a relative, friend, or patient. Help is at hand and it should be sought out quickly. Depression is now a readily treatable illness and advantage should be taken of that fact. The Dean of Freshmen Students at Harvard made a cogent remark regarding the need for skilled medical and psychiatric help to college students: "With so many wonderful kids on the beach, it pays us to have capable life guards at hand." Meanwhile, we might think of depression as did Leigh Hunt, who said in 1797:

> "If you are melancholy for the first time, you will find upon a little inquiry that others have been melancholy many times and yet are cheerful now."


SOC · MED · & CHIRURG · TERRÆ MARIÆ · SIGILL · MENSE · JUNII · A · D · 1799 & LIBERT · AMERIC · 23 to
INSTITUT ·
ΠΟΛΛΩΝ ΆΝΤΑΞΙΟΣ ΆΛΛΩΝ

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on March 6, 1969, and took the following actions:

1. Made appointments as follows:

   Maryland State School Health Council—Margaret L. Sherrard, MD, Baltimore County, for an additional three-year term

   Advisory Committee on Foster Care, State Department of Social Services—William M. Seabold, MD, Baltimore city

   Board of Physical Therapy Examiners—(One to be selected for a five-year term from each list submitted to the Governor)—

   Ernest Burch, Jr., Otto Payton, and Barbara Yerger
   William F. Lang, Gilbert Fine, and Ruth Latimer

2. Advised the Maryland Society of Anesthesiologists that it should list names of anesthesiologists who would be willing to serve on the Board of Trustees of Blue Shield, and who would be willing to attend meetings. When the list is received, it will be given due consideration at the next meeting (January 1970) when these appointments will be discussed.

3. Declined to take action in connection with proposed Nurse-Midwife legislation. The Council has previously opposed such action; and there are some problem areas that need discussion. The bill's sponsors are to be asked to meet with Faculty representatives to discuss this further.

4. Declined to participate in a proposed Orient tour as suggested by International Travel Advisors, Inc. of St. Louis.

5. Discussed some mutual problem areas with representatives of the Maryland Nursing Home Association; and deferred the appointment of a special committee or referral of these matters to an already existing Faculty committee until the incoming president can make such a decision.

6. Deferred action in connection with the Social Security Employee Health Program until the Medical Director can meet with the Executive Committee to discuss this further.

7. Deferred action in connection with a proposed Glaucoma Screening Project at Social Security until item 6 can be resolved.

8. Heard that the Maryland Pharmaceutical Association had adopted a policy similar to that of the Faculty's regarding the unethical direct telephone lines between a physician and a pharmacist; and also heard that the C & P Telephone Co. may not legally deny such service to persons requesting it.

9. Heard a report on the Faculty's Medicaid discussions with representatives of the Governor. It would appear that State Health Department statistical data in this area is not valid; and that until such time as valid data can be obtained, no proposals can be made other than having Blue Cross and Blue Shield act as fiscal agent.

10. Authorized the Executive Secretary to investigate the costs involved in consolidating all Faculty pamphlets, publications, etc., into one publication for easier reference by physicians.

11. Heard that Harold P. Biehl, MD, Baltimore, who was recommended to the State Health Commissioner as a candidate for a position on the Maryland Occupational Health and Safety Advisory Board, will be considered when a vacancy occurs.

12. Approved of submitting the name of John E. Adams, MD, Baltimore, as an additional advisor to the Blue Shield Board.

13. Selected Melvin Borden, MD, to represent the Faculty at an AMA sponsored conference on Nursing in Chicago, April 11 and 12, 1969.

14. Agreed to notify the JCAH that it did not provide sufficient time to investigate the question of any "problem situations" in various hospitals in Maryland. A reply was requested within seven to ten days.

    Also agreed to advise JCAH that there may be some problems of which the Faculty is not aware and that more time should be allowed for a response; and suggested that individual hospital staff physicians be given adequate notice of JCAH visits for accreditation so that such individuals may be given an opportunity to talk with JCAH investigators.

15. Agreed not to pursue further the question as to the amount of tax-deductibility a physician could make in connection with the 1968 cruise convention.

16. Authorized Manning W. Alden, MD, Annapolis, and Richard D. Bauer, MD, Adelphi, to attend an AMA meeting on the proposed revision of JCAH standards as representatives of the Faculty.

17. Determined that the 1965 Council ruling is applicable in connection with payment by Blue Shield for laboratory services rendered outside a physician's office.

    > If a clinician and a laboratory share the responsibility for a laboratory procedure, each should send a bill for services rendered. No physician should be denied a reasonable fee for obtaining a specimen for testing purposes and/or interpreting the results of the test, but this should be itemized separately and appear on the physician's statement.

18. Heard that the Nurses Liaison Subcommittee had under consideration the question of performance of medical services by other than those licensed to perform them; and also outside of the scope of currently issued licenses. Another report will be made at a later date.

19. Approved a contribution to the Maryland League of Nursing, as budgeted in the 1969 budget.

20. Approved loan of the portrait of Crawford Long, MD, to be used at the Pratt Library in connection with a Woman's Auxiliary display honoring Doctors' Day.

21. Read the folowing letter from the Faculty's legal counsel into the record of the minutes:

> "I have noted with interest the report of the Executive Committee's work at its January 9, 1969 meeting, including the statement that it 'learned that no insurer for professional liability would cover a physician for any "punitive damages" award.' In order that the Executive Committee may not be deemed to acquiesce on the question as to whether or not a particular policy may cover a particular physician in this respect, I suggest that you put this letter in the Executive Committee's files, so as to indicate that it, while listening with interest to communications made to it by insurance carriers continues to defer to advice of legal counsel in these respects. This should adequately indicate that the Executive Committee and the Medical & Chirurcal Faculty does not necessarily adopt, accept or acquiesce in such a position."

22. Designated the following persons to represent the Faculty at a Public Affairs Meeting in Washington, D.C. on May 17 and 18, 1969: Council Chairman, Council Vice-Chairman, President-Elect and Executive Secretary.

23. Authorized the use of Osler Hall on Sunday, May 25 by the Baltimore Association of Medical Assistants, with that group underwriting any necessary expenses in this connection.



MALPRACTICE ALERT

Physicians in Maryland are reminded they should ensure they are giving statements to AUTHORIZED PERSONS only when discussing any malpractice actions in which they may be involved.

Instances have occurred when insurance representatives of other companies have taken statements from physicians after representing themselves as "the adjuster from the insurance company." In some cases, meetings have been arranged by hospital personnel, with a request to the physician involved to attend. The physician mistakenly believes the meeting to be one in which *his malpractice insurance carrier* is involved. Only too late, he finds he has given information to the hospital insurance carrier which is used to the physician's detriment.

Another cautionary note to physicians, who may be involved in alleged professional negligence, concerns his freely discussing the case with other physicians or persons. In many cases, this can work to the detriment of the physician; not the least of which is the case in which he involves other physicians at a later date.

The above information reflects the importance of a physician judicially discussing any instances of alleged professional liability with which he may be concerned. Should there be any doubt in a physician's mind as to with whom he is to discuss his case, he should make every effort to contact the carrier directly and ascertain the correct procedure to be followed.

MEDICAL NEWS

Norman Levin, MD, chief of the Department of Obstetrics of Lutheran Hospital of Maryland, has been elected president of Lutheran's Medical Staff.

A 1947 graduate of the University of Maryland School of Medicine, Dr. Levin took his residency in obstetrics at West Baltimore General Hospital.

* * *

The newly elected President of the Medical Staff at Mercy Hospital is **Frank A. Faraino, MD. Gerald Galvin, MD,** was elected vice-president and **Robert Mahon, MD,** was elected secretary-treasurer.

* * *

Rennert M. Smelser, MD, was appointed to the Committee on Medicine of The Professional Forum. In this capacity, he will serve a two-year term as vice-chairman for the section on general surgery. **William E. Gilmore, MD,** is chairman.

* * *

James E. Carson, MD, the state mental hygiene commissioner, is hoping to embark this year on a program to house mentally retarded children in residential centers rather than in state hospitals. Dr. Carson said that such centers would provide "a bridge between living at home and being in a larger hospital."

* * *

The **Boards of Trustees** of The Johns Hopkins University and The Johns Hopkins University Hospital announced their approval of the development by Johns Hopkins of a voluntary program of prepaid, comprehensive medical care in the new city of Columbia in Maryland. This decision to proceed was made by the Hospital and University Boards of Trustees at their respective meetings on Tuesday, February 4 and Monday, February 10.

Through this medical plan, Johns Hopkins will develop new methods of delivering high quality health care to a defined population at reasonable cost.

* * *

Paralleling the Columbia activity, Johns Hopkins announced in December plans to join with the residents of East Baltimore to organize a similar form of comprehensive health care or other health care programs which best suit the needs and desires of the local community. **Torrey C. Brown, MD,** assistant professor of medicine, was appointed director of the East Baltimore program. Both the Columbia and the East Baltimore programs of health are under the direction of the newly-created Office of Health Care Programs at The Johns Hopkins Medical Institutions headed by **Robert M. Heyssel, MD.**

* * *

A group of behavioral scientists have launched a unique fellowship program in suicidology, an emerging profession for the study and prevention of suicide. This group from The Johns Hopkins School of Medicine is supported by a five-year, $852,000 grant from the National Institute of Mental Health.

Seymour Perlin, MD, director of the suicidology program and professor of psychiatry, feels that "suicide is a disease of such proportions that it must be considered a public health problem."

* * *

The Johns Hopkins University School of Medicine dedicated and named its new auditorium building on December 6, 1968, in honor of **Thomas B. Turner, MD,** who retired after 11 years as the dean of the Hopkins medical faculty.

The speakers included: **Alexander Heard, MD,** Chancellor of Vanderbilt University; **Dr. Turner,** dean emeritus; **David E. Rogers, MD,** dean of the medical faculty; **Lincoln Gordon, MD,** president of The Johns Hopkins University; and the **Honorable Thomas J. D'Alesandro, III,** mayor of Baltimore.

* * *

In the **first organ transplant to be performed at the University of Maryland Hospital,** a 20-year-old college student received a kidney donated by his mother on December 16. The 2½ hour operation was performed by a transplant team headed by **C. Thomas Flotte, MD.**

Maryland's third kidney transplant patient was discharged from the hospital on January 20. He was the first of three kidney transplant patients in Maryland to resume a normal life.

The first kidney transplant was performed November 1 at City Hospitals and the second, December 8 at The Johns Hopkins Hospital. Almost 2,000 kidney transplants have been performed elsewhere around the world.

* * *

Wilbur J. Cohen, Secretary of Health, Education, and Welfare, announced that the SMI premium rate for the period July 1969 through June 1970 will remain at the present $4.

The Social Security Administration is now meeting with the carriers to determine what additional administrative steps can be taken to keep payment for services in line with the monthly income of $8 per capita derived from premiums plus the matching amount from general Federal revenues.

* * *

As announced last September, the **Hospital Deductible Amount** — the amount for which the Medicare beneficiary is responsible—increased from $40 to $44, effective January 1. Comparable 10% increases are also effective in the dollar amounts as Medicare beneficiary pays toward a hospital stay of more than 60 days or for post-hospital extended care of more than 20 days.

* * *

The **Director of Public Health Service** has announced that the National Institute of Mental Health has unified all its programs in the field of narcotic and drug addiction under one division. Previously, the activities in this area, which encompass research, training, and services were administered by three separate Divisions of the Institute.

To head the Division of Narcotic Addiction and Drug Abuse is **Sidney Cohen, MD, PhD,** a research scientist of international repute who has lectured and written extensively on the subject of drug abuse.

* * *

Med-Chi's Councilors

Richard Y. Dalrymple, MD, took office as Councilor after the 1969 Annual Meeting held earlier this month. Dr. Dalrymple is the chief of surgery at Carroll County General Hospital.

He received his MD degree at Temple University Medical School, and completed his internship at Temple University Hospital in 1940. In 1960 he had finished his surgical residency at Maryland General Hospital.



Dr. Dalrymple

* * *



Dr. Kimble

Acting as a Councilor for the South Central District until 1971, is **Seruch T. Kimble, M.D,** of Silver Spring. Dr. Kimble holds membership in numerous professional and civic organizations, including, the American College of Physicians, of which he is a Life Fellow, the American Medical Association, the Association of American Physicians and Surgeons, and the International Society of Internal Medicine.

Dr. Kimble received his MD at George Washington University, and completed his internship at Presbyterian Hospital in Chicago. After his medical residency at Suburban Hospital in Bethesda, Maryland, he served various posts in the Army. Presently, he is involved in the private practice of internal medicine.

* * *

Robert Johnson Thomas, MD, of Frederick, assumed his duties as Councilor from the Western District after the 1969 Annual Meeting.

Presently, he is an attending surgeon at Frederick Memorial Hospital. Dr. Thomas is a member of the University of Maryland Surgical Society, and serves on the Board of Directors for the Frederick County Cancer Society. He is also a Fellow in the American College of Surgeons and the Southeastern Surgical Conference.

After receiving his MD degree from the University of Maryland School of Medicine in 1959, he completed his internship at Mercy Hospital, and in 1964 he finished his surgical residency at the University of Maryland Hospital.

* * *



Dr. Thomas



Dr. Ball

John G. Ball, MD, will continue to hold the position of Councilor from the South Central District until 1971. He has been a Delegate from Montgomery County since 1950. In 1964 he also held the position of Vice-President of the Faculty. In addition to his active participation in Med Chi, Dr. Ball is a member of various other organizations in which he holds office. He was also President of the Maryland Academy of General Practice for the 1967-68 year.

Dr. Ball received his MD degree from Buffalo University Medical School in 1936, and completed his internship at Emergency Hospital in Washington, D. C. He is a general practitioner in Bethesda, Maryland.

* * *

Is It a Moral or Ethical Issue?

During an interview at the Belvedere Hotel on April 10, Denton Cooley, MD, the eminent heart surgeon from Houston, Texas told inquiring members of the press that he has been involved in heart surgery for 25 years and "has done more heart surgery than anyone else in the world" and therefore feels he is qualified to judge what is best for his patients in the matter of life or death.

Dr. Cooley's method of preserving the life of Haskell Karp of Illinois, by employing an artificial supportive device, is now under investigation by the National Heart Institute at the request of its Director, Dr. Theodore Cooper.

Later that afternoon, Dr. Cooley addressed the audience attending the Scientific Sessions of the Faculty's Annual Meeting. He spoke on the *Experiences with Cardiac Transplantation in Man.* Dr. Cooley quoted Dr. Christian Barnard who said, "Is it moral or ethical to bury an organ which could save a life?"

* * *

Dr. Cooley's lecture will appear in a future issue of the JOURNAL.

KATHERINE ROBB
Nursing Home

REST HOME For Aged and Convalescents

4105 Essex Rd. near Liberty Rd.

HUnter 6-5656 BALTIMORE, MD.

Visit the #1 Spot for Your Diet Needs

Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)

For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic

SPECIAL DIET SHOP
Phone SA 7-0383

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number, the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.

COMPONENT SOCIETIES

Prince Georges County Medical Society

The Prince George's County Medical Society has, through its members, expressed its willingness and determination to back Bill No. 149 submitted by Senator Steinberg and now pending the Governor's signature. The Bill which permits doctors, among other professionals, to incorporate their practices has become law in as many as 36 states, and the physicians of Prince George's County were asked to urge the passage of this legislation for the State of Maryland.

In its last meeting, the Prince George's County Medical Society took up and discussed the contention of the Blue Cross of Maryland that the physician who has a laboratory perform work for his patient and then incorporates the change into his fee for service, is acting unethically and therefore refuses compensation. A resolution was passed for the Prince George's County Medical Society to go on record stating that as long as the laboratory charge of the physician to the patient does not exceed the fee charged for the same procedure, directly to the patient, by any other laboratory, the action of the doctor is ethical and in line with the common practice in this area. There was also the opinion voiced from the floor, "that the Blue Cross, an insurance agency, should not concern itself with medical ethics of the physician, but the reimbursement of justified claims to its insured clients."

Baltimore County Medical Association

The Baltimore County Medical Association met at the Greater Baltimore Medical Center on Wednesday, February 19, 1969. The meeting was called to order by the president, Dr. Theodore Patterson. Dr. Patterson thanked Dr. Everett Diggs and Dr. Thaddeus Prout who arranged the scientific program.

Application for Membership: On proper motion, the application of Charles Crimy, MD was approved for active membership.

Committee Reports: Board of Governors—Dr. Venable, chairman, reported a meeting of the Board was held on January 15th at our new headquarters. The carpeting has been installed, the drapes are up, and the secretary has a rented desk. The new furniture will be received sometime in March. At the November meeting, the members approved an expenditure up to $1500.00 for new office equipment, however, it was learned an additional amount will be needed, therefore, the Board approved an additional expenditure of $500.00. The legislative committee planned a dinner-meeting with the Baltimore County Delegation for Monday, February 10th in Annapolis. This was a very profitable "get-together." A Health Careers Day is being planned in cooperation with the Baltimore County Department of Health, the Baltimore County Board of Education, and the Essex Community College to be held on Sunday, May 18th at the college. Medical and paramedical careers will be highlighted. The Board approved an amount up to $100.00 for this purpose. Dr. Hornick plans to conduct a program to test Rubella Vaccine among parochial school children and the Health Department would like the approval of the association. These items were approved by the membership. TABCO (Teacher's Association of Baltimore County) has requested the Board of Education to put in their budget funds to pay for influenza vaccination for teachers in the county. Dr. Snyder moved to approve the influenza vaccine program and motion was seconded. After much discussion, the motion was defeated.

Inter-Agency Council on Smoking and Health: Dr. Barbara Solomon is the representative of our association and she stated the bylaws of the State Department of Education prohibiting smoking on school premises by students has been changed to allow local county option as to whether it will allow smoking in the schools. A letter has been sent recommending that the ban continue in the high schools. Dr. Solomon stated the agency would like a donation of $5.00 from each organization represented in the council so they may buy stationery. On proper motion, the association approved a $5.00 donation for this purpose.

Clarence McWilliams, MD, our representative on the School Insurance Committee of the Board of Education, requested any member who has a complaint about the present school insurance program to contact him following the meeting inasmuch as the School Insurance Committee will be meeting next week.

There being no further business, the meeting was adjourned.

Scientific Program: The subject of the program was "Problems in the Prevention and Treatment of Cardio-Vascular Disease." The introduction was made by Dr. Thaddeus Prout, who was the moderator. "Exercise for Prevention of Heart Disease," William L. Haskell, PhD; "Work Evaluation Unit at GBMC," George C. Roveti, MD; "Problems in the Diagnosis of Coronary Artery Disease," "Gottlieb C. Friesinger, MD; "Case Reports: Cardio-Vascular Disease," Geary L. Stonesifer, MD.

Our thanks to Greater Baltimore Medical Center for an informative and timely presentation.

JOHN M. KRAGER, MD
Secretary

Baltimore City Medical Society

The Board of Directors of the Baltimore City Medical Society met at 1211 Cathedral Street on February 11, 1969 at 4:30 p.m. The meeting was called to order by Raymond C. V. Robinson, MD, President.

The minutes of the January 14th meeting were approved as distributed.

In response to a request for continuation of membership in the Health and Welfare Council, the Board agreed to investigate the activities of this organization before making a final decision.

The Board considered several items of correspondence from the Medical and Chirurgical Faculty. The first dealt with a request for a nominee to receive the Citizen's Service Award. At the suggestion of D. Frank Kaltreider, MD, the Board unanimously selected Mrs. Alexander S. Cochran as its nominee. Mrs. Cochran has been active in the School Board Sex Education Program, has served on the advisory boards of several community hospitals, is active in the Planned Parenthood Association, and exemplifies an earnest unselfish interest in many community humanitarian programs. A list of Mrs. Cochran's services will be forwarded to the Faculty's Public Relations Committee for consideration.

In response to a request from the Med-Chi Nominating Committee for suggestions to be considered by it when preparing a slate for the elective offices of the Faculty, the Board agreed to submit the following:

To serve as five councilors from the Central District—Raymond C. V. Robinson, MD, Robert B. Goldstein, MD, Philip F. Wagley, MD, D. Frank Kaltreider, MD, and James R. Karns, MD.

Delegate to the American Medical Association—John N. Classen, MD
Alternate Delegate—Edward F. Cotter, MD
Member of the Committee on Program and Arrangements—David E. Rogers, MD
Member of the Library and History Committee—Arthur E. Cocco, MD
Member of Finney Fund Committee—Jack M. Zimmerman, MD
Members of the Board of Medical Examiners—Lester Kieffer, MD, Worth B. Daniels, Jr., MD, and John T. Chissell, MD.

No nominees are to be submitted for the offices of President-elect and Vice President. The Board agreed to renominate William A. Pillsbury, MD, as Secretary and Karl F. Mech, MD, as Treasurer.

The President-Elect of Med-Chi requested that the Society submit names which he might consider in making committee appointments for the coming year. However, after consideration, the Board agreed that this was the prerogative of the President-Elect and that if any individual members of the Board wished to make any suggestions these should be sent to the Society office.

Permission to use the Society's mailing list was granted to the Baltimore City Unit of the American Cancer Society with the stipulation that the list not be passed to other groups without the direct approval of the Society.

The recognition afforded Doctors of Osteopathy under the Medical Practice Act makes consideration for their admission as members of the Baltimore City Medical Society mandatory. After much discussion, D. Frank Kaltreider, MD, proposed that the Bylaws of the Society be altered so as to accept Doctors of Osteopathy as active members of the Society. This proposal was referred to the Bylaws Committee for action.

The Faculty Executive Committee, at the request of the Board of Directors, has agreed to allow the Baltimore City Medical Society to hold

its General Meetings on the first Thursday of each month beginning in October. This necessitates a change in the "snow date" policy of the Society which states that meetings cancelled by inclement weather will be held the following week. The Board agreed that in the future the policy will be to hold any meetings cancelled by snow on the following night.

A letter from Mayor Thomas J. D'Alesandro, III, expressing gratitude to the Board for its support and recommendation of the reappointment of Robert E. Farber, MD, as Health Commissioner for Baltimore City was read.

The Community Chest-Red Cross United Appeal headquarters reported that the division in which physicians are classified surpassed its goal for contributions.

Dr. Robinson reported that an agreement had been reached to offer financial assistance in an amount up to $500.00 and some secretarial assistance to the Woman's Auxiliary to the Baltimore City Medical Society. The Board agreed with this arrangement.

Authorization was granted to the Medical and Chirurgical Faculty Medication Committee to investigate charges made against a member of the City Society.

The name of Helen Taussig, MD, was placed in nomination to be considered by the Selection Committee of the American Medical Association as a recipient of the Sheen Award. This award is given for outstanding contributions to medicine and it seemed obvious that Dr. Taussig's achievements would command the respect of the Selection Committee.

The Board agreed that a letter be written to the President of Med-Chi stating that financial support of members of the Society who are in need should be forthcoming, but that prior to such support a thorough investigation of the members' financial status should be made, and the component society should be informed of the pending action.

At the suggestion of the Nominating Committee a letter to all members soliciting suggestions for the various elective offices of the Baltimore City Medical Society will be included in the next mailing. These suggestions will be considered by the Nominating Committee when it prepares the slate of officers for 1970.

Note was made of a letter received from the State Health Department concerning the budget proposals for support of the Medical Assistance Program in Maryland for 1969-1970. The report attached to this letter offers a breakdown of the program and is on file in the Society office.

The Chairman of the Legislative Committee, Howard Moses, MD, met with the Board to present the suggestion made by the Med-Chi Legislative Committee that component societies arrange meetings with their respective legislators. After some discussion, it was agreed that this means of exchanging ideas was probably advantageous in small communities, but that Baltimore City encompasses such a large number of legislators it would be more worthwhile to meet on a personal basis to discuss specific topics.

The Board agreed to circularize the membership in order to update the files in the Society office which are used in making referrals. A questionnaire will be enclosed with the next mailing which all members are requested to return stating whether or not they wish to be included in the Society's list of referral physicians.

The final item on the agenda was a discussion concerning the membership participation in the activities of the Society. The Board expressed a sincere desire to stimulate the interest and participation of the membership in the activities of the Society. Obviously the achievement and fulfillment of any society's goals can only be accomplished by the enthusiastic participation of its membership. Many aspects of this problem are presently under consideration. In reality, however, the reasons for the lassitude are multiple and complex, and the Board would, therefore, be appreciative of constructive criticism and remedial methods offered by the members of the Society.

The meeting adjourned at 6:00 p.m.

Arthur E. Cocco, MD
Journal Representative

MANUEL SCHWARTZ
HEARING REHABILITATION
321 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201
DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION
Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

no gag



DIA-QUEL actually tastes good

DIA-quel contains the only therapeutically active ingredient of paregoric—tincture of opium. This has been combined with homatropine methylbromide and pectin to make a sensible antidiarrheal formula.

By leaving out paregoric's outdated preservative—bitter-tasting camphor—we've produced an antidiarrheal that is good-tasting, as well as effective and prompt-acting in acute, nonspecific diarrheas and their accompanying "cramps." It is DIA-quel, a clear, red liquid with a pleasant cherry flavor.

Each teaspoonful (5 ml.) of DIA-quel Liquid contains:
Tincture of Opium... 0.03 ml.—Equivalent to 0.75 ml. of paregoric.
(Warning: May be habit forming)
To reduce hypermotility and frequency.
Homatropine Methylbromide... 0.15 mg.
A safe dose for mild spasmolysis to curb cramping and griping.
Pectin... 24. mg.
Demulcent, adsorbent. Helps form stools.
Alcohol 10% by volume.

In case you're curious, back in the 1700's paregoric was being used for diarrhea, but since the state of the pharmaceutical art was extremely primitive, fungus growth in the medication was a problem. Bitter-tasting camphor was added to prevent such growth and anise oil was added in an attempt to cover up the camphor taste. DIA-quel Liquid is a modern formulation that does not contain either of these outdated ingredients.

Caution: With use of DIA-quel Liquid observe the usual precautions associated with opium derivatives and anticholinergics.

Dosage: Usual adult dosage: 1 or 2 tablespoonfuls (15 or 30 ml.) t.i.d. or q.i.d. Usual children's dosage (Clark's rule): ½ to 2 teaspoonfuls (2.5 to 10 ml.) t.i.d. or q.i.d.

How Supplied: In 4 fl. oz. (118 ml.) band-sealed bottles.

DIA-quel is a Federally exempt narcotic (Class X) preparation. Where state law permits, no prescription is necessary.

For a complimentary sample of DIA-quel, simply mail your request to us on a signed prescription blank.

DIA-QUEL LIQUID

IPC
REG. U.S. PAT. OFF.

INTERNATIONAL PHARMACEUTICAL CORP.
Warrington, Pennsylvania 18976

The Month In Washington

The American Medical Association told Congress that the Internal Revenue Service acted arbitrarily and completely ignored the facts in imposing a tax on revenue from drug advertising in journals of tax-exempt medical associations.

Bernard D. Hirsh, AMA general counsel, testified before the House Ways and Means Committee, that the relation between the tax-exempt purposes of a medical association, national or state, and the drug advertising in its journal is self-evident.

"Drug advertising alerts and stimulates the physician's interest in new drugs as they become available, and also serves to remind him of the broad spectrum of useful time-proven drugs," Hirsh said. "Obviously physicians should not and do not rely upon drug advertisements as their principle source of information, but drug advertisements often provide an important step in the process through which physicians become educated in the therapeutic value and risks of new drugs and a wider variety of useful drugs. . . . No other advertising provides as much complete and objective information."

Hirsh said the IRS regulations taxing medical associations on their advertising revenues represents an attempt to change the law without congressional action. The IRS officials made a mistake, he stated.

"We urge that this mistake be rectified expeditiously and in the most practical way possible."

Spokesmen for numerous other tax-exempt associations joined the AMA in opposing the tax on their advertising revenues. These included the American College of Physicians, the American College of Obstetricians and Gynecologists, the American Psychiatric Association, the American Dental Association, the Boy Scouts of America, the Girl Scouts of America, the American Chemical Society and the Society of National Association Publications.

Representatives of commercial publishing firms contended in testimony before the committee that the previous tax exemption gave the journals of the associations an unfair advantage in competition for advertising dollars. When the IRS announced the new tax regulations 15 months ago, it stated that the purpose of the regulations was *not* to raise federal revenue but to remove a competitive advantage of the tax-exempt associations.

In an announcement not directly connected with the House committee hearings, the IRS said it also is considering taxing the income tax-exempt associations get from rental of exhibit and display space at conventions.

* * *

A special advisory committee urged the development of an extensive national program to combat alcoholism.

A spokesman for **the National Advisory Committee on Alcoholism** said in an interim report that attention should be given to alcoholism problems in all federally supported health and welfare programs. The committee also recommended:

- Elimination by hospitals of discriminatory policies denying admission to alcoholic patients;
- health insurance coverage for alcoholics;
- increased support for research;
- prevention and control of alcoholism as a vital part of national highway safety programs.

The advisory committee provides advice and guidance to the Secretary of Health, Education and Welfare concerning the department's activities related to alcoholism. Robert Straus, PhD, professor of medical sociology at the University of Kentucky Medical School, is chairman of the committee which was created in October 1966. Its members represent all sections of the country and include experts from the fields of medicine, psychiatry, sociology, vocational rehabilitation, law, and public health.

"The magnitude of the problem is enormous," Dr. Straus stated. "Our country has more than five million alcoholics. Their suffering alone is intolerable, but the need for increased action is made even more imperative by the fact

that affected families may include as many as 20 million Americans."

He also emphasized that alcoholism has a tremendous impact on business, causing absenteeism and loss of productivity.

* * *

The National Institute of Mental Health awarded a first-year grant of $250,000 for a major alcoholism research program at the State University of New York, Downstate Medical Center, New York, N.Y.

The five-year program will include experimental and clinical studies, training, and drug trials. In one study, 60 newly admitted patients between the ages of 25 and 55, with at least a five-year history of alcoholism, will be studied to determine the effects of experimentally induced intoxication and withdrawal on the subjects' sleep patterns, behavior and biochemistry. The investigators will focus upon the mechanisms underlying the development of physical and psychological dependence.

Among the drugs to be tested are haloperidol, dexoxadrol, disulfiram (Antabuse), paraldehyde and chlordiazepoxide. The drugs will be tested alone and in combination with a tranquilizer and an antidepressant.

* * *

The Federal government is planning to launch a five-year, nation-wide program of inoculation against the rubella virus (German measles) as soon as a vaccine is licensed and available in sufficient quantities. The vaccine is expected to be available next fall.

By March 1 of this year two drug manufacturers had announced they had developed a vaccine. Two others were developing one. Merck & Co., Rahway, N.J., was the first to announce completion of testing such a vaccine. The Merck vaccine, which is of the HPV-77 strain, was reported 95% effective in vaccination of 18,000 children and adults. Merck also has been testing a one-shot vaccine against German measles, common measles and mumps.

PEPI Inc., New York, N.Y., said that it had developed a modified live-virus vaccine, also of the HPV-77 strain, for the disease and that, after being licensed, it would be marketed by Philips Roxane Laboratories and Parke, Davis & Co. PEPI said initial production would be primarily a single-dose vaccine for use in pediatric practice, but that later production would include dosage forms suitable for government-sponsored mass-vaccination programs.

The other two companies developing a rubella vaccine are Smith Kline & French Laboratories, Philadelphia, and Eli Lilly & Co., Indianapolis. Eli Lilly has been developing a HPV-77 strain. Smith Kline & French was working on a Cendehill strain. It has proved 95% effective in inoculations of more than 25,000 persons, according to the manufacturer. Another vaccine, using the rubella strain RZ27-3, has been developed at the University of Pennsylvania.

* * *

Rep. Ancher Nelsen (R., Minn.) has introduced legislation calling for the same Federal tax treatment of professional corporations of physicians organized under state law as for business corporations.

"We are overdue in acting to guarantee this same right of organization to professional persons that we have always given other forms and types of businesses," Nelsen told the House.

He noted that the Federal government's so-called Kintner regulations, issued in 1960, primarily keyed taxation of professional corporations to state law.

"As a result," he said, "many states, Minnesota included, passed laws enabling incorporation under these regulations. Assuming the air was cleared, many corporations were formed. However, in 1965, the Internal Revenue Service issued new regulations reversing its position, which if upheld, make it almost impossible to create a professional corporation, regardless and in spite of state laws permitting the same.

"No business can operate without some basis of continuity of the ground rules. If any set of rules should be stable, the rules governing the basic tax classification of businesses for tax purposes should be stable and not subject to administrative whim. Businesses, almost without exception—except for the professions with which this bill deals—are now allowed to decide whether to adopt the partnership, association or corporate form under applicable state laws. There is no logical reason for denying this choice to persons who are rendering personal services in the medical or legal fields. Fairness and equity in applica-

tion of the Federal income tax laws demands that all businesses be treated alike in this sense.

"The only apparent reason for the 1965 amendments to the regulations was to prevent a possible reduction in Federal revenues. I am certainly convinced that this is not an adequate reason for ignoring years of legal precedent and congressional intent in this field. Furthermore, the providing of health, pension and profit-sharing plans through tax incentives under the corporate structure is a worthy objective and a legitimate use of the tax laws. Indeed, I am advised that any possible total tax revenue loss will be minimal when it is realized that most profits will be ultimately taxable, even though such taxation might be immediately deferred.

"The position taken by the Internal Revenue Service in 1965 is untenable. It violates fairness, equity, reasonableness, years of legal precedent, and the intent of Congress as to the tax treatment of business organizations operating legitimately under state law. I would urge all my colleagues to support hearings and passage of this needed legislation at the earliest possible date."

* * *

Sen. Clinton Anderson (D., N.M.) introduced a bill to tie medicare and medicaid payments to hospitals and nursing homes to local Blue Cross allowances. The bill complements a measure introduced by Sen. George D. Aiken, (R., Vt.) earlier this year which ties physicians' charges to Blue Shield schedules. Aiken co-sponsored Anderson's bill. Co-sponsoring both bills are Sen. Mike Mansfield, (D., Mont.) and Sen. Winston L. Prouty (R., Vt.). Anderson co-sponsored Aiken's bill.

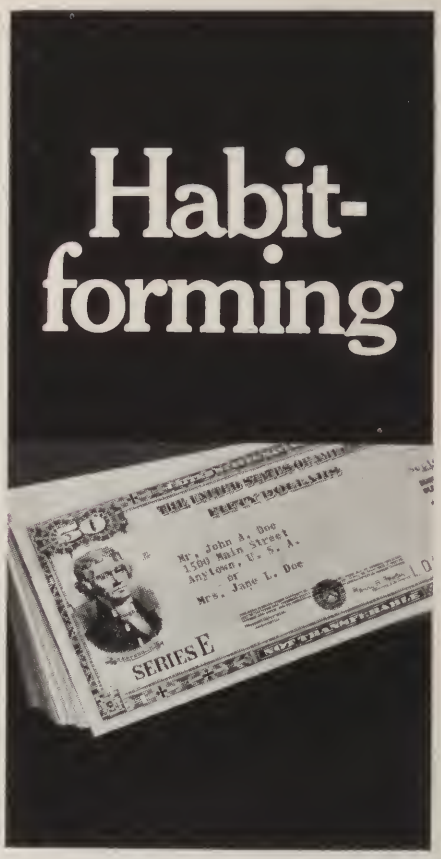
Anderson also said he supports the idea of Sen. John J. Williams (R., Del.) that Congress should give medicare and medicaid programs a closer look, perhaps a full-dress investigation.

MED-CHI SEMIANNUAL MEETING

SEPTEMBER 4, 5, 6

For information on the happenings,

Watch future issues of the Journal



When you stack one U.S. Savings Bond on top of another, it becomes a habit that's tough to break and hard to beat. That's because it's so painless. Just tell your employer or banker to set aside a regular amount for you before you have a chance to spend it. Sign up today.

New Freedom Shares

Bonus opportunity for people who buy Bonds through the Payroll Savings Plan or Bond-a-Month Plan — a new U.S. Savings Note called Freedom Shares. It pays a higher rate of interest and matures faster. Get all the facts where you work or bank.

U.S. Savings Bonds, new Freedom Shares

his ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

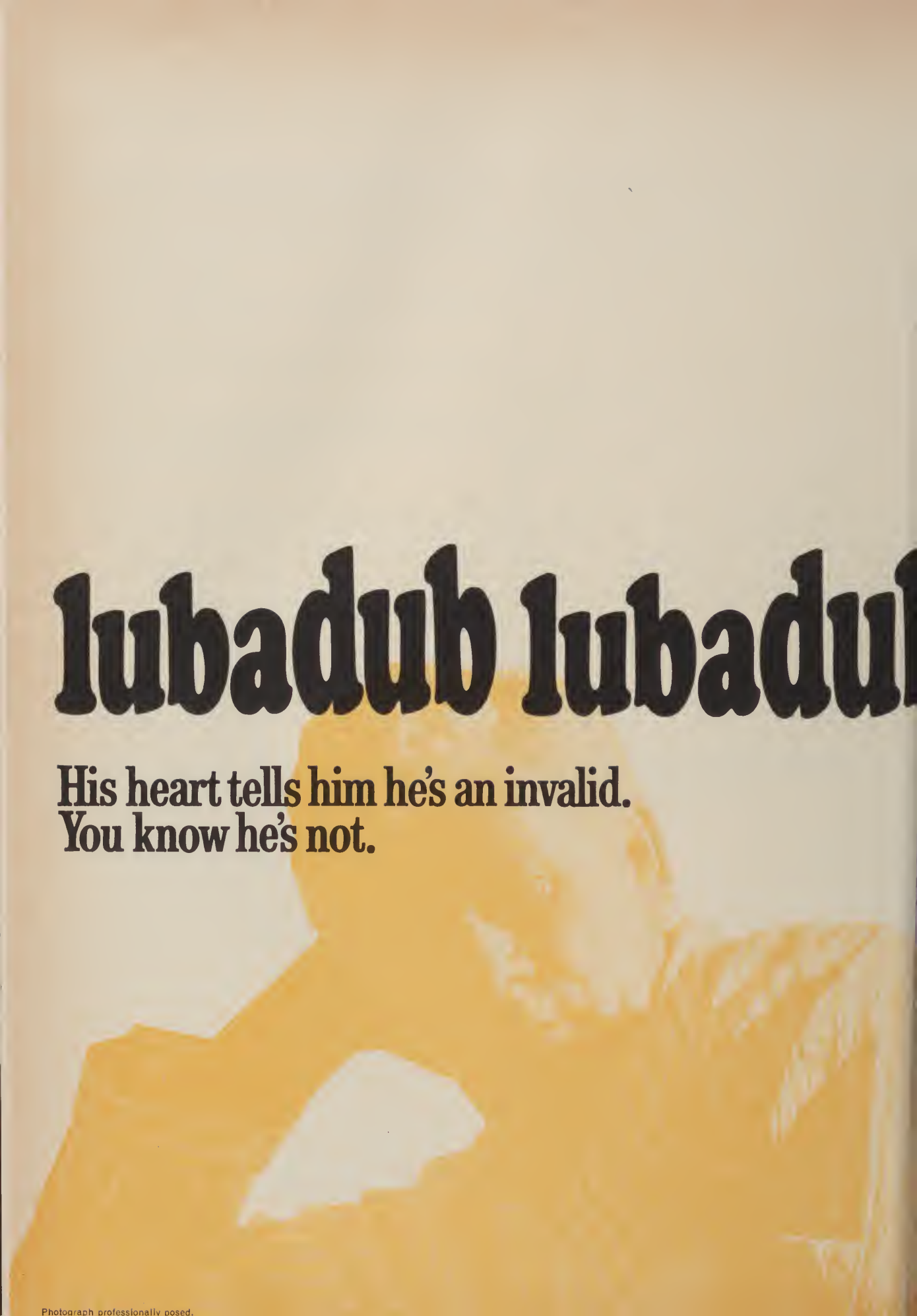
Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®

ibadubdub lubadu

xiety is expected in the cardiovascular patient.
ittle may even be desirable.

t when anxiety is exaggerated . . . when it
erferes with sleep . . . when it aggravates
diovascular symptoms, your help may
needed.

turally, you'll want to reassure the patient.

d perhaps prescribe Equanil (meprobamate)
adjunctive therapy. It helps relieve anxiety
d tension specifically, yet gently.

most 15 years' use has shown that Equanil
usually well tolerated as well as effective.
le effects are generally limited to transient
owsiness; serious, therapy-interrupting
le effects are rare.


P
M
P
M

A little sunshine for summer cold and allergy sufferers.

ahistine LP can brighten things in
rry for your summer cold and
gy patients.
e continuous-release, deconges-
tablets contain a vasoconstrictor-
istamine formulation that goes to
promptly and usually provides
tive relief even in those cases
sal congestion caused by repeated
gic episodes.
convenient twice-a-day dosage
with Novahistine LP lets most patients
enjoy relief all day and all night.
Use with caution in patients with
severe hypertension, diabetes
mellitus, hyperthyroidism or urinary
retention. Caution ambulatory patients
that drowsiness may result.

PITMAN-MOORE Division of
The Dow Chemical Company,
Indianapolis, Indiana.

DOW

Novahistine®
LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

MARYLAND—DISTRICT OF COLUMBIA SOCIETY OF ANESTHESIOLOGISTS

SYMPOSIUM ON

ACUTE RESPIRATORY FAILURE

Holiday Inn Downtown, Howard & Lombard Sts., Baltimore

Saturday, May 17th, 1969 9:00 AM to 6:00 PM

9:00-10:00 AM:	Demonstration of Ventilators
10:00-10:45 AM:	"Principles of Mechanical Ventilators." Leslie Rendell-Baker, MD, Professor and Chairman, Department of Anesthesiology, The Mount Sinai Hospital and School of Medicine, New York.
11:00-11:45 AM:	"Ancillary Methods—Inhalation Therapy, Humidification, Physical Therapy." Meyer Saklad, MD, Anesthesia Research Department, Rhode Island Hospital, Providence, R.I.
12:00- 2:00 PM:	Lunch
2:00- 2:45 PM:	"Medical Treatment of Acute Respiratory Failure." Reuben M. Cherniack, MD, Professor of Medicine, The University of Manitoba, Winnipeg.
3:00- 3:45 PM:	"Use of Respirators in Acute Respiratory Failure." Henrik H. Bendixen, MD, Department of Anesthesia, Massachusetts General Hospital and Harvard Medical School, Boston, Mass.
4:00- 4:45 PM:	Questions
5:00- 6:00 PM:	Demonstration of Ventilators

Registration Fee $15. (Residents $5.) Includes Lunch, Morning and Afternoon Coffee.

Make Checks Payable To: Maryland—D.C. Society of Anesthesiologists

And Send To: T. Crawford McAslan, MD
Dept. of Anesthesiology, Univ. of Md. Hospital
Redwood & Greene Sts., Baltimore, Md. 21201

Al-Lin Ambulance Service
"AT THE BELTWAY"
4811 E. LEEDS AVE. BALTIMORE, MD. 21227
24 Hour Emergency Ambulance and Oxygen Service
Trained and Experienced Personnel
2 Way Radio Controlled
247-2111

COLOSTOMY ILEOSTOMY
Appliances and Disposable Bags
CALL
FIELDS PHARMACY
IN PIKESVILLE
for convalescent supplies and service
FOR RAPID DELIVERY 486-3300



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

A Therapeutic Approach to Osteoarthritis

The Arthritis Foundation (Maryland Chapter, 12 W. 25th St., Balto., Md. 21218) is arranging a series of articles by experts on arthritis to appear from time to time in Rehabilitation Notes.

JAMES M. SOWA, MD
Fellow-in-Medicine, Connective Tissue Division
The Johns Hopkins University School of Medicine

Our usual goal of therapy is control of disease and the same goal should be kept in sight for osteoarthritis. Too often the physician, as well as his patient, succumbs to an inordinant pessimism about osteoarthritis and how nothing can be done about structural degenerative changes. Perhaps by broadening our concept of therapy we can introduce a brighter outlook.

A thorough initial diagnostic evaluation is necessary.[1, 2] Rheumatic complaints are often the presenting symptoms of other diseases, or the somatic masks of underlying anxiety states or depressive reactions. It will also become readily apparent that radiological changes are often unrelated to the symptomatic complaints. Indeed, a large percentage of patients with terrible looking X-rays have minimal or no symptoms. When this occurs the wisest course is probably to avoid mention of it and thus not direct the patient's attention to an asymptomatic, although structurally diseased area. In this way your therapeutic efforts may be directed to the primary problem, whether a different disease, osteoarthritis elsewhere, or an underlying emotional disturbance.

In our therapeutic plan[3-8] first must come definite and confident reassurance of the patient about the nature of osteoarthritis. The very word arthritis often conjures up a specter of pain, unsightly deformity, and the cripple in a wheelchair. Just as Stephen Vincent Benet termed rheumatoid arthritis "a mean disease," we might call osteoarthritis a nagging disease. Just the knowledge that his is not a "crippling arthritis" might relieve a patient of enough emotional tension and fear to accept a peaceful coexistence with osteoarthritis. If done early enough, many patients might never require the use of sedatives, tranquilizers, etc., which emotional responses based on ignorance have made so prevalent.

With initial reassurance, therapy is directed toward the body structure and how it affects the disease process. Probably the greatest offender in this regard is fat. For any effective results, the extra stresses and strains upon the skeletal system from obesity must be removed by a gentle, yet firm insistence upon weight reduction. If prominent low back or cervico-thoracic complaints are present, certain temporizing measures may be

necessary until weight is normal. These might include back supports, a good corset to support the flabby abdomen, a well-fitted brassiere for large, pendulous breasts.

Attention to posture, too frequently ignored, may result in alleviation of abnormal stresses and strains acting upon the spine and lower extremities. Good shoes giving proper support to the feet are important. Shearing stresses, so important in damage to the knee, are particularly to be avoided. Looking into activities on the job, at home, and in leisure time is almost certain to reveal a few possible changes. Poor support from chairs on the job or at home, a poorly designed work bench, or poor leverage of instruments might all be corrected. Rather than constantly stand while ironing, the housewife might use a tall stool for part of the time. Does the kitchen have an adequate functionally arranged work space, or must the woman twist, turn, and bend while working for the family? Is the bed too soft? Similar evaluation of leisure habits is necessary. Surely the patient with lumbosacral, hip, or knee disease is only aggravating his problem with golf. The problems pertinent to tennis, bowling, etc., become obvious from evaluating the peculiar stresses each of these activities introduces.

The osteoarthritic patient, in contrast to the rheumatoid patient, finds that activity increases his stiffness and pain. It is amazing how stoic some people become, such as waitresses, enduring great discomfort because of an economically necessary job. Yet continuous work in the face of severe pain is only abusing the joint. Use of rest periods, perhaps an extended version of the popular coffee break, might allow the patient to complete a full work day in comfort. Unless such rest periods can be integrated into the work schedule, an alternative, less taxing job should be considered.

Although rest is necessary, too sedentary a life leads to muscle atrophy and cartilage inanition. An old saying has it that the life of a joint is in motion and this must be preserved. It is the balance of rest with beneficial activity that presents a problem similar to that in the rheumatoid patient. Physical therapy is directed toward maintaining normal motion and muscle strength through therapeutic exercises. Unless the physician has the training and the necessary time for individual instruction, his patient is best referred to a physical therapist. This referral should detail the problem areas and what the physician hopes to accomplish for the best choice of an effective program.

Therapeutic exercises are particularly effective when used with adjuncts such as, moist heat (a hot tub bath) and gentle massage. There is no particular advantage to be derived from much more expensive and time consuming physician-directed modalities such as ultrasound.

In addition to the simple supportive aids mentioned above, another important mechanical measure to relieve abnormal stress is a cane. Occasionally, a brace or crutches will relieve instability and slow further destruction. In some patients, a surgical approach is necessary to give relief. For example, when torn menisci or joint mice produce pain, limit motion, and cause locking of the joint, surgery is an effective and simple therapy. When poor angulation leads to a valgus or varus deformity, a well-timed osteotomy is effective and even preventive therapy. A painful joint, properly selected, can respond to arthroplasty. The hip, frequently a major problem in osteoarthritic patients, is amenable to several effective orthopedic approaches. The key to such patients is a thorough initial evaluation and appropriate consultation.

Diet has little role in osteoarthritis apart from any necessary weight reduction. Because the disease is so prevalent among the elderly, a nourishing high protein and high calcium intake might be beneficial. Vitamin and mineral supplements are unnecessary and a waste of the patient's money, unless specifically indicated.

Lastly in this presentation, and in the care of the patient, are drugs. Most patients will require analgesic-anti-inflammatory drugs. In terms of cost, minimal side-effects, and effectiveness, aspirin is the drug of choice. A regimen of 0.9 gm taken three or four times daily is usually effective. The cheapest of the many preparations available is usually sufficient. Some patients may require a buffered aspirin or an enteric-coated preparation because of gastric upset. With the enteric-coated formulations, obtaining reliable blood levels may be a problem because of poor absorption. An occasional patient may prefer one of the salicylate-phenacetin compounds which are also efficacious. As an adjunct, the analgesic dextropropoxyphene may be used.

In some situations intra-articular steroids, such as prednisolone tertiary butyl acetate, are useful and very gratifying. The benefits of such injections may last from a week to several months with an average somewhere about one month. Dependent upon the situation they may be repeated

as a palliative measure. Too frequent injections should be discouraged. Each is a potential portal for infection. Moreover, when there is a response there is the real danger of overstressing a diseased joint and consequent accelerated destruction. In contrast to intra-articular therapy, at no time should systemic steroids be used in this disease.

There are indications for use of other drugs, particularly among those with severe hip disease and sometimes with spinal involvement. Phenylbutazone is a well-known drug and very effective in hip and spinal problems. For long-term management the dosage should be 100 to 300 mg daily. The physician should require periodic blood counts because of the possibility of bone marrow suppression. Indomethacin is a newer drug, effective in generally the same situations as phenylbutazone, with potent anti-inflammatory and analgesic properties. In a dosage of 25 mg three or four times daily it may be efficacious. The dose may be raised to a maximum of 200 mg daily, but at higher dosage levels headache, gastrointestinal upset, and psychic disturbance become more frequent, especially in elderly patients.

Summary

In a chronic disease with so many extraneous influences as osteoarthritis, a gratifying therapeutic result may be obtained by broadening our definition of therapy. Reassurance of the patient about the non-crippling nature of his disease is a primary factor in alleviating the emotional fears and tensions generated by a diagnosis of arthritis. Secondly, attention to weight reduction, posture, the abnormal stresses of job, home and leisure activities will bring added relief. Judicious use of mechanical aids—from shoes through canes and braces—are another factor. Surgical intervention in the well selected patient affords excellent relief of symptoms. A balance of rest and therapeutic exercise is essential. Drugs are a minor, although necessary adjunct. Aspirin and intra-articular steroids are the primary drug therapies with indomethacin, phenylbutazone and dextropropoxyphene playing important secondary roles.

REFERENCES

1. Sokoloff, L. "The pathology and pathogenesis of osteoartbritis," in Arthritis and Allied Conditions, edited by Hollander, J.L., 7th ed. Philadelphia, Lea & Febriger, 1966, pp. 849-869.
2. Abrams, N. R. "Symptoms and laboratory findings of osteoarthritis," ibid, pp. 870-885.
3. Abrams, N. R. "Treatment of osteoarthritis," ibid, pp. 886-898.
4. Hartung, E. F. Osteoarthritis: current methods of treatment. *Arth. & Rheumat.* 6: 389-397, 1963.
5. Watkins, A. L. Therapeutic exercise in rheumatoid arthritis. *Arth. & Rheumat.* 2: 21-26, 1959.
6. Kraus, H. Principles and Practics of Therapeutic Exercise. Springfield, Ill., Charles C. Thomas, 1949.
7. Hettinger, T. *Physiology of Strength.* Springfield, Ill., Charles C. Thomas, 1961.
8. Bowie, M. A. "Physical therapy in arthritis," in Arthritis and Allied Conditions, edited by Hollander, J. L., 7th ed., Philadelphia, Lea & Febriger, 1966, pp. 481-527.

Insurance For The Doctor

PROFESSIONAL LIABILITY*

Workmen's Compensation
Equipment Floater
Bonds on Employees
Public Liability
Fire Insurance
Disability Income
Term Life Insurance
Pension Plans

* *Endorsed by MEDICAL SOCIETY OF D. C. & MD.*

Russell, Marsh & Kennedy, Inc.

5151 WISCONSIN AVE. WASHINGTON, D. C. 20016 244-7600



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Admission Rates at Record Level in all Age Groups

Admission rates to Maryland's state-operated mental hospitals increased in all age groups between 1961 and 1967. That is, admissions proportionally increased much faster than the general population. As shown in the following table, rates approximately doubled in all age categories between 15 and 65, and rose at a somewhat lower percentage in the two upper age groups. The total admission rate increased 74.0% (from 193.3 to 336.3 per 100,000 Maryland residents five years of age or older) during this six-year period. Preliminary estimates for the current 1969 fiscal year indicate a further rise in the admission rate to approximately 375.

AGE-SPECIFIC ADMISSION RATES*—FISCAL YEAR

AGE GROUP	*1967*	*1965*	*1963*	*1961*	*CHANGE (1967-1961)*
5-14	23.7	19.5	18.9	16.5	+7.2
15-24	215.9	199.0	184.2	158.4	+57.5
25-44	549.1	438.8	368.7	280.8	+268.3
45-64	511.1	365.8	343.2	235.7	+275.4
65-84	329.2	348.0	325.8	294.1	+35.1
85 & Over	699.7	690.5	745.9	577.7	+122.0
TOTAL	336.3	275.2	248.9	193.3	+143.0
MEDIAN AGE	41.0	40.4	41.2	40.7	+0.3

* Number of admissions per 100,000 estimated Maryland residents in specified age group.

Comparable data have been reported from most other states. Primarily, this upward movement reflects the growth in the number of admissions for short-term intensive treatment of acute nonpsychotic disturbances, together with the increase in the number of patients requiring multiple episodes of care. Schizophrenia and other psychotic disorders accounted for 36.7% of the 5,266 admissions in 1961 and 22.6% of the 11,091 admitted in 1967. During this period, admissions for disorders related to old age decreased from 11.5% to 6.1% while admissions for alcoholism, other personality disorders and psychoneurotic reactions rose from 36.7% to 59.4%. In 1961, 59.4% of all admissions reported no previous psychiatric hospitalization. By 1967 this had decreased to 45.8%. The current rate is 39.1%.

Since the median length of hospitalization of new admissions has been progressively reduced to less than two months, this has not produced a comparable rise in the number of resident patients. Rather, the 74.0% increase in admissions occurred concurrently with a decrease of 5.0% in the average number of hospitalized patients (from 8,428 in 1961 to 8,006 in 1967). The average size of the patient population for the current year is expected to decrease further to 7,425.

Mental hospitals are in a state of transition with a gradual shift from a chronic long-term custodial population receiving minimal care to an acutely ill patient group requiring maximum, high-level professional services. Average daily expenditures per patient must, therefore, be expected to rise further, and a continuing increase in employee-patient ratios is imperative if present treatment levels are to be maintained.



A Service of the Tuberculosis Association of Maryland

tuberculosis

Treatment of Disseminated Mycotic Infections

Amphotericin B was administered in low daily doses over a ten-week period in the treatment of patients with histoplasmosis, blastomycosis, and cryptococcosis. Results are encouraging, and suggest new guidelines for amphotericin therapy.

In an effort to avoid the toxic side effects of therapy with amphotericin B, a new approach to its administration has been tried in the treatment of such mycotic infections as histoplasmosis, cryptococcosis, and blastomycosis. It is based on giving the drug in smaller daily doses and over longer periods of time than is usually employed.

With the objective of attaining daily peak serum levels of amphotericin B at least twice those necessary for *in vitro* inhibition of the infecting fungus, serial amphotericin B serum level determinations were used as guidelines to the daily drug dosage of each patient. Frequent monitoring of the serum levels provided an objective means for regulation of daily dosage, and permitted modification of dosage if associated illnesses complicated the situation or renal function declined.

Fifteen patients with histoplasmosis, blastomycosis, or cryptococcosis were treated by this method. Amphotericin B was administered daily in gradually increasing doses until the desired peak had been reached. The dose was infused slowly over a four- to six-hour period. Heparin was routinely added to each infusion to prevent phlebitis. Blood for serum level determinations was obtained from 45 minutes to an hour following completion of the daily infusion. Peak serum levels persisted for six to eight hours and remained stable when a constant daily dose was established. Sensitivity tests were made regularly.

David J. Drutz, MD; Anderson Spickard, MD; David E. Rogers, MD; and M. Glenn Koenig, MD. *The American Journal of Medicine,* September 1968.

Other Disorders

Five patients had histoplasmosis, three had blastomycosis, and seven had cryptococcosis. All had disseminated disease except for two of the cryptococcosis patients. Eleven had diabetes mellitus but did not take insulin. One patient with histoplasmosis had underlying lympholeukosarcoma and another was receiving adrenal corticosteroid therapy for rheumatoid arthritis. One patient was receiving steroid therapy for sarcoidosis. Other medical problems included Addison's disease in two patients; a seizure disorder and rheumatic mitral valvular prosthesis in one; mild azotemia in four; and congestive heart failure was a complicating factor in four.

Acute toxic reactions were rare. When they did occur, it was at a time when the daily amphotericin B doses were increased or the daily infusion was delivered rapidly.

Eleven of the patients are alive and have been free of infection for periods ranging from 8 to 45 months after a single ten-week course of amphotericin B therapy. Two patients with histoplasmosis have died of myocardial infarction, one during therapy and the other three months after completion of treatment. A third patient was killed in Viet Nam more than two years after successful treatment of extensive pulmonary cryptococcosis. The fourth patient who died had histoplasmosis and was the only one retreated. Post-

mortem examination revealed widespread lymphosarcoma and pulmonary nocardiosis but no evidence of active histoplasmosis.

Results Satisfactory

Results achieved with most of the patients indicate that mycotic infections may be treated successfully with relatively small daily doses of amphotericin B and without predetermined goals for total drug dosage. Monitoring of the serum level of amphotericin B provided a guideline, whereby daily dosage could be governed by the sensitivity of the infecting fungus and changes in renal function.

Although the goal of achieving a daily peak serum concentration of amphotericin B at least twice that required for inhibition of the fungus *in vitro* was arbitrary, it was thought that such levels might suppress the infecting fungus and allow host defense mechanisms to control the infection. Experience in treating subacute bacterial endocarditis and tuberculosis had indicated that the duration of therapy was of greater importance than attainment of maximum drug serum levels or specific total drug doses.

The desirability of determining the amphotericin B sensitivity of the pathogenic yeast phase was recognized in the biphasic histoplasma and blastomyces organisms. However, because of various problems, the less fastidious mycelial phase was used in sensitivity tests.

Serum levels in this study were higher than those usually reported for amphotericin B. With drug doses approaching 1 mg per kg of body weight a day, serum levels reached 6.3 μg per ml in one patient. In the one patient who received 1.5 mg per kg per day, a level of 12.5 μg per ml was recorded.

The question has been raised of the possibility of the development of drug resistance with prolonged use of amphotericin B in relatively small doses. However, on the basis of other studies on fungal resistance to amphotericin B, it appears unlikely that fungi resistant to the drug will be a hazard in the regimen discussed.

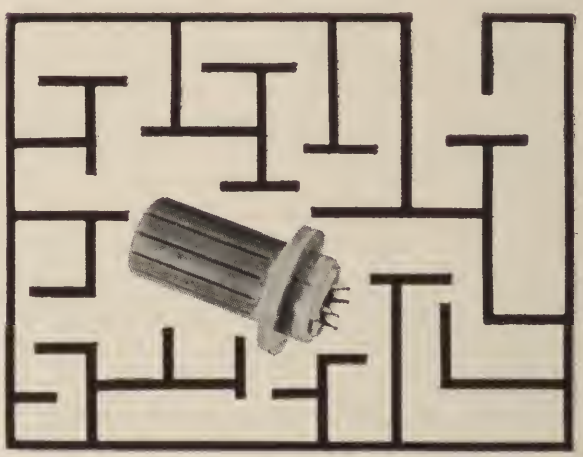
The relative freedom observed in this study from such acute toxic side effects of amphotericin B as nausea, vomiting, and fever has not been reported in other studies. The most important factor in this decrease in side effects is believed to have been the small daily doses of amphotericin B used.

Toxicity

However, the regimen did not prevent other toxic manifestations. Phlebitis was common and necessitated the prophylactic use of heparin in each infusion. Hypokalemia developed in a third of the patients, and renal function became impaired in each one during the course of treatment. The subsequent return of renal function after completion of therapy suggests that the degree of permanent renal damage resulting from amphotericin B administration is a function of the total dose administered. Thus, the present treatment regimen may produce less permanent impairment of renal function than other regimens.

Anemia was another occurrence and red cell aplasia developed in two patients during therapy, but red cell production returned to normal after amphotericin B therapy.

On the whole, the therapeutic results with this regimen have been encouraging. The laboratory studies involved are simple and easily taught to technicians with minimal mycological training. The approach provides a rational basis for therapy and allows treatment of patients with impaired renal function and other severe underlying medical disorders.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

473-9

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Dr. Ann Webb Appointed Clinical Director For Handicapped Children

Ann H. Webb, MD, has been appointed clinical director for the Division of the Handicapped in the Child Health Services section of the Baltimore City Health Department.

Dr. Webb will be responsible for the evaluation and follow-up of handicapped children referred for assistance to the department by private physicians, hospitals, public health nurses, schools, and other city agencies. She will work in close cooperation with the Bureau of School Hygiene and other personnel in the Bureau of Public Health Nursing and the Child Health Services section.

Dr. Webb has been a part-time school physician for the past two years. In addition to her school health work she has assisted in the Division of the Handicapped for the past six months.

Educated in the schools of New York city, Dr. Webb, a graduate of Vassar, received her MD from Columbia University College of Physicians and Surgeons in 1964, and during that time received a two-month Public Health Service grant to study the public health aspects of tropical medicine in Surinam, Dutch Guiana. Prior to coming to the Health Department, she received pediatric training at the University of Virginia Hospital in Charlottesville and the Mary I. Bassett Hospital in Cooperstown, New York.

The City Health Department's Division for the Handicapped registered 1,575 children during the past year and now has on its rolls a total of 26,781 since this program began in 1956. The division is under the supervision of John B. Saratsiotis, MD, director of the Bureau of School Hygiene in the Baltimore City Health Department.

Evaluation Report Of Medical Aspects Of Early School Admissions Program

An evaluation of the City's Early School Admissions Program of the Baltimore city public schools has been conducted by Science Research Associates for the school year 1967-1968 and this past summer. Some excerpts of this report are as follows:

> A comprehensive health and medical program was provided by the Baltimore City Health Department in conjunction with a recently organized Comprehensive Medical Services program for indigent children. Full range medical, dental nursing, and psychological, diagnostic, preventive, and remedial services were included. . .
>
> Judging from teacher, principal, and parent comments during interviews, it appears that the health and medical services, provided Early Admissions children, were identified as the best of the ancillary services.
>
> Because of the comprehensiveness of the program, a detailed analysis is beyond the scope of this evaluation. However, a report of the health services provided indicates the scope and quality of the program. The Bureau of School Hygiene is to be commended for the excellent coordination and use of many community resources. . . . Included, in addition to what is usually provided in health and dental programs, were Mental Health teams who were active throughout both summer and winter programs.

The Early School Admissions Program was inaugurated in 1962 as a special three-year educational program financed jointly by the Baltimore city public schools and the Ford Founda-

tion. This was continued in 1966 with the financial assistance of the Federal Elementary-Secondary Education Act. Up to now a total of 6,000 children have benefited from this program.

The aim of the program is to enrich the lives of culturally deprived four- and five-year-olds through overcoming academic handicaps which face them on entrance into the elementary school program. Central to the success of this program is home, parental and community participation.

The Early School Admissions Program was a forerunner of the Federally funded national Head Start program of the Office of Economic Opportunity which was based in large measure on Baltimore's experience. Mrs. Catherine Brunner is supervisor of Early Childhood Education in the Baltimore public schools and Dr. Saratsiotis directs the school health program, a responsibility of the Baltimore City Health Department.

Opportunity is afforded here to express thanks to the many physicians and others who are participating in this program.

CONTINENTAL . . .





The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

PROFESSIONAL LEASING
Special low rates for our medical customers. Call or stop in.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL

5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

We lease car,

not cars (plural). Car (singular). When a professional man like you wants just one car.

We do one-car-at-a-time leasing with plans particularly appropriate for the professional man. Plans designed to give you the same advantages as enjoyed by big companies that lease.

These advantages include: the new '69 you want as you want it, no capital tied down in a depreciating asset, no separate maintenance or insurance bills, convenient service without extra charge at thousands of "Happy Motoring"® stations throughout the United States, exact transportation costs records on a single monthly bill for tax accounting, no trade-in problems or losses.

Many physicians and surgeons are now leasing. With good reason. Ask your nurse or secretary to drop us a note, or call us, for a detailed booklet explaining the Humble Leasing Plan.

HUMBLE LEASING COMPANY
1766 Morris Avenue
Union, New Jersey 07083
Telephone: (301) 837-4510





JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Wolff-Parkinson-White Syndrome

Wolff, Parkinson, and White first defined the syndrome which bears their names, and sometimes called the pre-excitation syndrome, as a clinical and electrocardiographic entity in 1930. They described 11 patients whose electrocardiograms showed a relatively short P-R interval with a slurred and widened QRS complex, usually followed by an abnormal T wave, and having a tendency to paroxysmal tachycardia. This combination of electrocardiographic abnormalities had been described earlier, but without the associated episodes of paroxysmal tachycardia.

JOHN J. MESSINA, MD
Instructor in Medicine
Director, Adult Cardiac Clinic
University of Maryland School of Medicine

The Wolff-Parkinson-White syndrome (W-P-W) has been the subject of numerous publications, but there has been no unanimity of opinion regarding its cause. Most writers agree that the most tenable hypothesis is that of ventricular pre-excitation via an anomalous or accessory atrioventricular pathway. Kent described such accessory pathways in rabbits, mice, and other animals as early as 1893. In 1932, Holtzman and Scherf, and, independently, Wolferth and Wood, postulated that the pre-excitation syndrome was best explained on the basis of an accessory pathway, although such a pathway had not been described previously in man.

In 1943, Wood and Wolferth demonstrated an anomalous atrioventricular muscular bundle (Bundle of Kent) in a young man who had had the pre-excitation syndrome and who had died during a paroxysm of tachycardia. Numerous reports of accessory atrioventricular bundles in persons with a history of the W-P-W syndrome have since appeared in the medical literature.

Age and Incidence

The W-P-W syndrome has been reported in all ages from early infancy to advanced age, although it initially was thought to be found primarily in otherwise healthy young adults. In newborns and infants, the diagnosis is definitive only if the typical deformity (the delta wave) of the QRS is present, because short P-R intervals are normally seen in this age group. The incidence of this syndrome is not known with certainty, but most authors agree that it is approximately 1.5 per thousand EKG's in a hospital population.

The even distribution of the W-P-W syndrome in all age groups favors its being a congenital variation, although nothing definite is known about hereditary factors governing its occurrence. A relatively high incidence of associated thyrotoxicosis has been reported, and the W-P-W syndrome also has been frequently associated with congenital cardiac defects, notably, Ebstein's Anomaly. Ap-

proximately 60-70% of reported cases occur in males.

Characteristics of the W-P-W Syndrome

The electrocardiographic criteria of a classical case of the W-P-W syndrome are:

1. A short P-R interval (0.10 sec. or less, in 85% of cases);
2. A prolonged QRS complex (0.11-0.12 sec., in greater than 50% of cases);
3. Slurring and slow rising of the onset of QRS complex in some of the leads. This is termed the delta wave, and is the most characteristic feature of the EKG;
4. Deviation of the RS-T segment and T-wave changes, and
5. A tendency to paroxysmal tachycardia (occurs in 12-80% of reported cases).

Mechanism

It is thought that the short P-R interval is due to the shorter distance between the S-A node and the accessory A-V bundle, as compared to the distance between the S-A node and the A-V node. The delta wave is thought to represent premature arrival of the wave of activation at the ventricles (ventricular pre-excitation). It, along with the prolonged QRS complex (often resembling right or left bundle branch block), is thought to represent an abnormal spread of the wave of activation (other than via the bundle branches and Purkinje system) through the ventricles. The RS-T segment and T wave changes are thought to represent aberrant ventricular repolarization.

The mechanism responsible for the frequently observed tachyarrhythmias is obscure. The re-entry phenomenon has been postulated by some investigators. In the case of paroxysmal atrial or A-V nodal tachycardia, a paroxysm of rapid heart action may be precipitated by passage of the ectopic atrial or A-V nodal impulse downward through the A-V node and its subsequent return to the atria or A-V node via the accessory pathway, thus constituting a form of re-entry. The paroxysmal tachycardia will persist if the re-entry phenomenon is repetitive.

Either normal or anomalous ventricular complexes may be seen when atrial fibrillation, atrial flutter, or paroxysmal atrial tachycardia are present in the W-P-W syndrome, since the electrical impulse may be conducted through either normal or accessory pathways. Usually, the more rapid ventricular rates are associated with anomalous QRS complexes, since the impulses arrive at the A-V node at a rate faster than the normal A-V nodal pathway is capable of conducting.

Prognosis

The W-P-W syndrome is usually benign, and there are no subjective manifestations or hemodynamic disturbances resulting from ventricular pre-excitation itself. However, paroxysmal tachycardia may occur at any time (during rest, exercise, or emotional upset), and sudden death during such an episode has been reported. Life insurance experience indicates that applicants with this syndrome are not standard risks, since their mortality rate is said to be approximately three times as great as that of individuals without the W-P-W syndrome.

Differential Diagnosis

The W-P-W syndrome is unique in that the diagnosis is made only by means of an electrocardiogram. Although easily recognizable in its classical form, it is misdiagnosed by physicians who initially see the patients, in approximately 30–50% of cases. Most often, the electrocardiograms are misinterpreted as acute myocardial infarction (especially inferior and anterior), left ventricular hypertrophy, or bundle branch block (right or left). It is also possible for the electrocardiographic features of myocardial ischemia or infarction to be masked in the presence of W-P-W syndrome.

Treatment

No specific treatment, aside from the avoidance of factors known to precipitate paroxysmal tachycardia, is required for the W-P-W syndrome during periods of normal sinus rhythm. Some authors, however, advocate the prophylactic use of quinidine, and more recently propranolol has been reported to be successful in preventing paroxysmal tachycardia. It is extremely important to unmask the electrocardiographic features of myocardial ischemia, myocardial infarction or ventricular hypertrophy when these are present. This is accomplished by conversion of the pattern of anomalous conduction to normal A-V conduction by such measures as cartoid sinus pressure, Valsalva maneuver, exercise, amyl nitrite, atropine, and quini-

dine. In general, the sinus tachycardia caused by amyl nitrite, atropine, and quinidine tends to abolish anomalous conduction whereas digitalis, neosynephrine and prostigmine may increase or precipitate it.

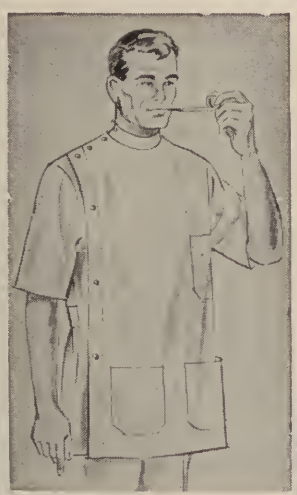
For treatment of paroxysmal tachycardia (especially atrial fibrillation with a rapid ventricular response). However, quinidine is the drug of choice. Since a combination of quinidine and digitalis may be used, quinidine acts to depress the anomalous pathway and digitalis the normal one. Vasopressors also have been used successfully in terminating the paroxysms of tachycardia, and more recently cardioversion has been found to be effective as well.

In view of the generally good prognosis when there is no associated heart disease, such patients with the W-P-W syndrome should be reassured concerning their condition, since they may suffer more from the electrocardiographic diagnosis (and sometimes mis-diagnosis) than from the anomaly itself.

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#800—100% Nylon Taffeta **$5.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only

Sizes 34 to 46





MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab. **$9.99**

Sizes 28-40

- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46



OTHER STORES IN →

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639

MEDICAL AND CHIRURGICAL FACULTY

OF THE STATE OF MARYLAND

MED-CHI

Members Retirement Plan

TRUSTEE AND ADMINISTRATOR

Mercantile-Safe Deposit and Trust Company

INVESTMENT ADVISOR

T. Rowe Price and Associates, Inc.

LIFE UNDERWRITER

Shenandoah Life Insurance Company

FOR MORE INFORMATION DETACH AND MAIL SLIP DIRECTLY TO:

MED-CHI MEMBERS
RETIREMENT PLAN
1211 Cathedral Street
Baltimore, Maryland 21201

Name .....

Address .....

City ..... State ..... Zip Code .....

Telephone Number ..... Date of Birth .....
(month) (day) (year)

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Highlights

Medically Indigent Restored to Medicaid Program

The Hon. Marvin Mandel, during his first week as governor of Maryland, issued a directive to the department to restore 22,000 medically indigent persons to the Medicaid Program who had been previously enrolled. The Health Department is delighted with this action and Commissioner Peeples has written a letter to Governor Mandel expressing this sentiment.

The governor's decision is an excellent one for several reasons: From the humanitarian standpoint, this is a very needy group and removal from the Medical Assistance Program has resulted in many cases of great hardship; this is also a definitive contribution to preventive public health and constitutes a long-range and enlightened economy.

As Dr. Charles Mayo said originally, and many have repeated since, "Sickness makes people poor, poverty makes people sick." The Governor's decision is a timely step in the direction of interrupting that cycle.

The department, in close collaboration with the Department of Social Services, is now making the necessary plans to get the machinery in motion to carry out the Governor's directive. It will be necessary for this group of individuals to reapply to their local Department of Social Services for reinstatement in the Medicaid program. This will take some time, but it is being expedited as quickly as possible.

Since July 1, when Medical Assistance was canceled for 22,000 people, plus those who were eligible but have an income above Maryland's "indigency" level, numerous inquiries and protests have been registered with the department. More than 1,500 telephone calls and almost 100 letters have been received from patients, their legislators, or others seeking help on the behalf of the indigent sick. In an effort to undersand why their needed medical care should not be provided, 432 patients visited the department and made pleas for special consideration.

1970 Fiscal Year Budget

The 1970 fiscal year allowance for the entire department totals $129,252,945 as opposed to the current 1969 fiscal year appropriation of $103,-911, 269.

The department requested $99,872,712 for Medicaid in 1970. The printed budget allows $68,230,-380. The 1969 appropriation is $50,164,821.

The amount allowed for Preventive Medical Services in the printed budget is $1,522,239. It should be noted, however, that much of the activities of the 24 local health departments are of a preventive nature, for example: family-planning clinics, maternity clinics, child health conferences, day-care centers, tuberculosis and venereal disease control activities, and other similar programs.

The amount estimated for community health services for the current 1969 fiscal year was $26,408,524. The estimated amount for fiscal year 1970 is $30,350,261.

State Executive Reorganization Proposed

An administration-backed bill submitted to the 1969 General Assembly would enable the Governor to select a Secretary of Health who would oversee the coordination of the present departments of health and mental hygiene, along with

25 boards and agencies, into one Department of Health and Mental Hygiene.

The reorganization also calls for the Secretary of Health to supervise the activities of the Department of Juvenile Services. In presenting the legislation, Governor Mandel said, "Juvenile delinquency should not be treated as a criminal problem, but as a health problem. Our handling of juvenile delinquency as a criminal problem just has not worked."

If the bill is enacted as submitted, the present State Board of Health and Mental Hygiene would be replaced by the Secretary of Health and a board of review.

The new secretary's responsibilities would include internal management of the department, establishment of areas of responsibility for budget presentation and expenditures, the appointment of a deputy secretary, and a general council, subject to the approval of the Governor. Also, he would be in charge of appointing and dismissing personnel.

The Board of Review would be composed of seven members serving staggered three-year terms. Three of the board's members would be experienced in the fields under the new department's jurisdiction. Four members would represent the public directly. All would be chosen by the Governor and would serve without pay.

The board members' duties would be to advise the secretary on the administration and operation of the department, and would hear all appeals to rules and regulations set by the department.

At this time, there are no indications of the expenditures necessary to implement the reorganization plan.



Give your home new beauty with
SKILLFUL LANDSCAPING
TREES, PLANTS, SHRUBBERY
expertly planned and planted
FREE ESTIMATES
BELTWAY GARDEN CENTER
7937 Belair Road, Baltimore Md. 21236 NO 8-3965

LDG
LUCAS DESIGN GROUP

Contract Interior Design Division of Lucas Bros., Inc.
221 East Baltimore St. ■ MU 5-3000

MERCEDES-BENZ
Baltimore's only Authorized Dealer for Sales, Service and Parts
R. & H. Motors, Inc.
4810 Belair Rd. 426-9200
Baltimore, Md. 21206

TOURS ARRANGED TO MEDICAL CONFERENCES AND CONCLAVES
Domestic and International
GLOBETROTTER TRAVEL
A Professional Travel Service
BALTIMORE: REISTERSTOWN ROAD PLAZA • 358-6444
BALTIMORE: MONDOWMIN SHOPPING CENTER 669-8200
WASHINGTON: WHEATON PLAZA SHOPPING CENTER

SKILL SURGICAL, INC.
SKILL
SUPPLIES & EQUIPMENT
for
PHYSICIANS—SURGEONS
HOSPITALS
5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and toler

or here.



ate Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

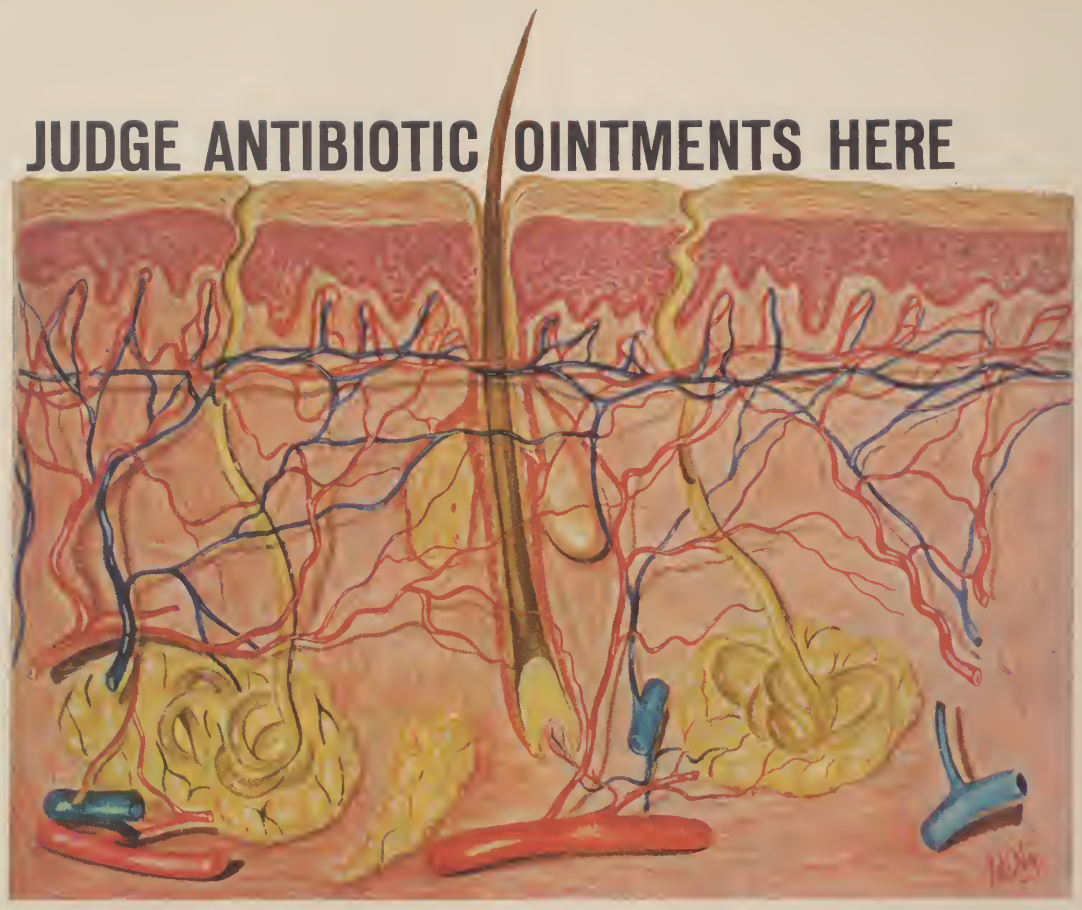
ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Emergency Medical Services

Alarm over the explosive increase in highway slaughter impelled Congress to pass the National Highway Safety Act in 1966. The Act requires States to meet minimum standards in 16 different areas affecting highway safety or forfeit 10% of the State's federal highway money (which could be as much as $7,000,000 in Maryland).

PERRY STEARNS, MD
Medical Consultant to the
Emergency Health Services Program,
Maryland State Department of Health



State Emergency Medical Services should reach minimum standards by 1971. Specific goals are:

1. Training and licensing of ambulance and rescue personnel.
2. Specifications for type and number of emergency vehicles, including supplies and equipment which shall be carried.
3. Requirements for the operation and coordination of ambulances and other emergency care systems.
4. First aid training programs and refresher courses for emergency service personnel and first aid courses for the general public.
5. Standardized two-way communications.
6. Standardized procedures for summoning and dispatching aid.
7. An up-to-date comprehensive plan for emergency medical services including: facilities and equipment, defined areas of responsibility and agreement for mutual support and communications systems.
8. Periodic evaluation of services and plan.

Emergency Medical Services (E.M.S.) includes ambulances, rescue squads, and emergency care facilities. Its responsibility ends at the hospital when the patient is delivered to the care of a physician. E.M.S. cannot prevent accidents but E.M.S. *can* prevent some of the deaths and disability resulting from accidents.

In 1968, Maryland had 867 fatalities resulting from 754 motor vehicle accidents. There were 54,325 reported injuries as a result of 94,513 accidents. No one knows how many deaths or disabling injuries could have been prevented with better ambulance service.

From the Subcommittee on Traffic Safety of the Medical and Chirurgical Faculty of the State of Maryland

When Professional Experience Counts

The House In The Pines Staff Is Able and Ready To Serve!



BEL AIRE . . . 5837 Belair Road • CL 4-8800

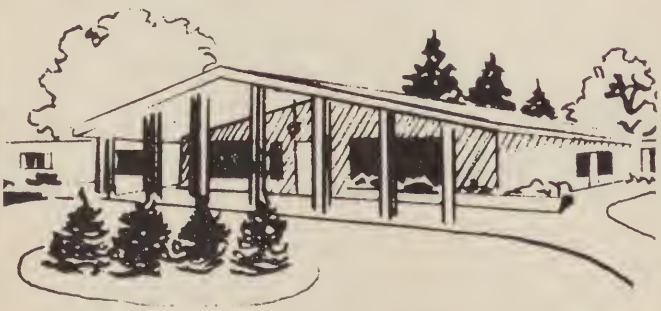


BELVEDERE . . . 2525 W. Belvedere Ave. • FO 7-9100

Conveniently located 1 block from Sinai Hospital.



CATONSVILLE . . . 16 Fusting Avenue • RI 7-1800



EASTON, Md. . . . Rt. 50 & Dutchman's Lane • TA 2-4000

HOUSE IN THE PINES Nursing and Convalescent Homes offer efficient, round the clock care under the direct supervision of registered nurses, 24 hours a day.

The aged, convalescent and the chronically ill guests enjoy a modern, home-like atmosphere with the most up-to-date medical and therapy equipment at their side.

Complete physical and occupational therapy programs are available. The recreational programs are designed to full-fill the needs and desires of our guests.

Excellent food is served, and special diets catered to, under the direct supervision of our licensed staff dietician.

Physicians orders are followed explicity!

HOUSE IN THE PINES
NURSING HOMES

Your Inspection Invited
Brochure Upon Request



MRS. HARRY L. BERMAN, EDITOR

Auxiliary Adjourns

The Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland adjourned this month, concluding one of its most progressive years. In addition to continuing ongoing projects and activities of past years, Mrs. H. Leonard Warres, the outgoing president and her able Board initiated and put into work a number of new health-related programs.

An Ad Hoc Committee on Youth and Violence was organized under Mrs. Howard Biehl to join forces with other groups interested in combating violence on radio, television, and in the movies along with a massive letter-writing campaign calculated to reach producers in these media. Our Annual Meeting speaker and panel focused on this new area of national concern.

A survey on how involved our members are in various productive activities, professions and services, and one concerned with statewide unmet needs of the elderly and shut-ins relating to home care such as "friendly visitors" and "meals services" were chaired with impressive results by Mrs. G. Allen Moulton.

Excellent Health Education presentations in the form of "Package Programs" were distributed to community groups for showing and discussion, covering such subjects as Teenage Venereal Disease, Youth, Health and Fitness, Mental Health of Children, Health Careers, Immunization, The Block Mother Plan, Homemaker Service and Sex Education.

The Auxiliary helped finance a new nurse recruiting film which has been selected for viewing at the National AMA Auxiliary at the Waldorf Astoria Hotel in July on the basis of its excellence.

Other promising "firsts" for the Auxiliary were the conducting of state-level workshops paralleling their national counterparts, covering all of the aspects handled at the Eastern Regional Workshops in Boston, and the enlistment of translation teams in communities outside Baltimore, in accordance with a proposal from Faculty members, to facilitate communication between physicians and patients unable to speak English. Credit must be given to the County Presidents and their Chairmen for their efforts in reaching those able and willing to communicate in various tongues.

In the interest and promotion of Health Careers, Mrs. Robert J. Dawson, State Health Careers Chairman, made significant progress in stepping up financial assistance to those wishing to go into paramedical fields. Scholarships given out this year surpassed last by an increase of over double. Harford County, although geographically small, initiated a big slide project with commentaries showing all the promising and rewarding opportunities available to young people there.

In the area of local Community Service, Mrs. Leland B. Ransom of Allegany County launched a first Family Life Program presenting well-

attended sessions on Sex Education of Children. Mrs. Louise Graff, Chairman of Community Service, Press and Publicity, Washington County, performed outstandingly in assembling and displaying ancient and historic memorabilia of that county's medical background.

The necessary task of revising the Bylaws was successfully undertaken by Mrs. Emerson C. Walden, Revisions and Resolutions Chairman. In other areas of auxiliary activity gainful work by Chairmen and committees were duly noted.

Last to be mentioned here, but far from least, three state-wide money-raising projects under the competent leadership of Elizabeth Linhardt, AMA-ERF Chairman, were completed with substantial gains for the ERF treasury. With each county participating in the Day at the Races the net amount raised was $616.20. Mini-shares, Christmas card sales and Doctors' Rose Bush returns have not had a final count at this writing.

A fond farewell to an industrious team and a salute to its successors!

Offering 2 GENERATIONS of research and experience in cooperation with the MEDICAL PROFESSION

CORRECT SHOES

for every Rx need

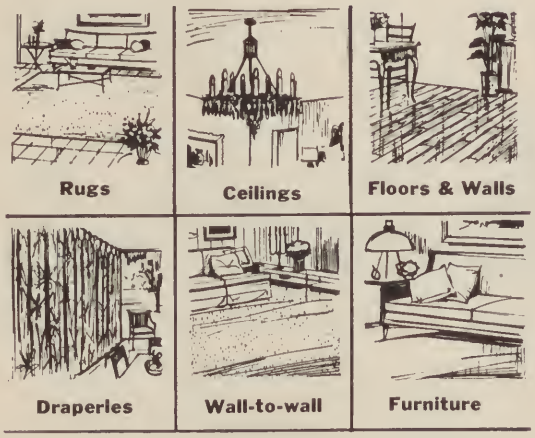
Normal	Pronators
Straight	Supinators
Corrective	D. B. Splints

Modifications and Custom Work

HERBERT COX

HU 4-0021
1433 Reisterstown Rd.
Pikesville 21208

SA 7-7883
210 N. Liberty St.
Baltimore 21201



TRUST CHESAPEAKE
To Clean Them All!

*Service*MASTER specifications for carpet and furniture cleaning are recommended by leading carpet mills and furniture manufacturers nationwide. TRUST CHESAPEAKE for expert cleaning of office wall-to-wall carpeting, rugs, furniture, draperies, ceilings, floors, walls. **488-3000**

CHESAPEAKE
Rug & Drapery Cleaners

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION
ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE
DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily
Tuesday Evenings 7 to 9

355-9300
PATAPSCO AVENUE & FOURTH STREET
Baltimore, Maryland, 21225

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

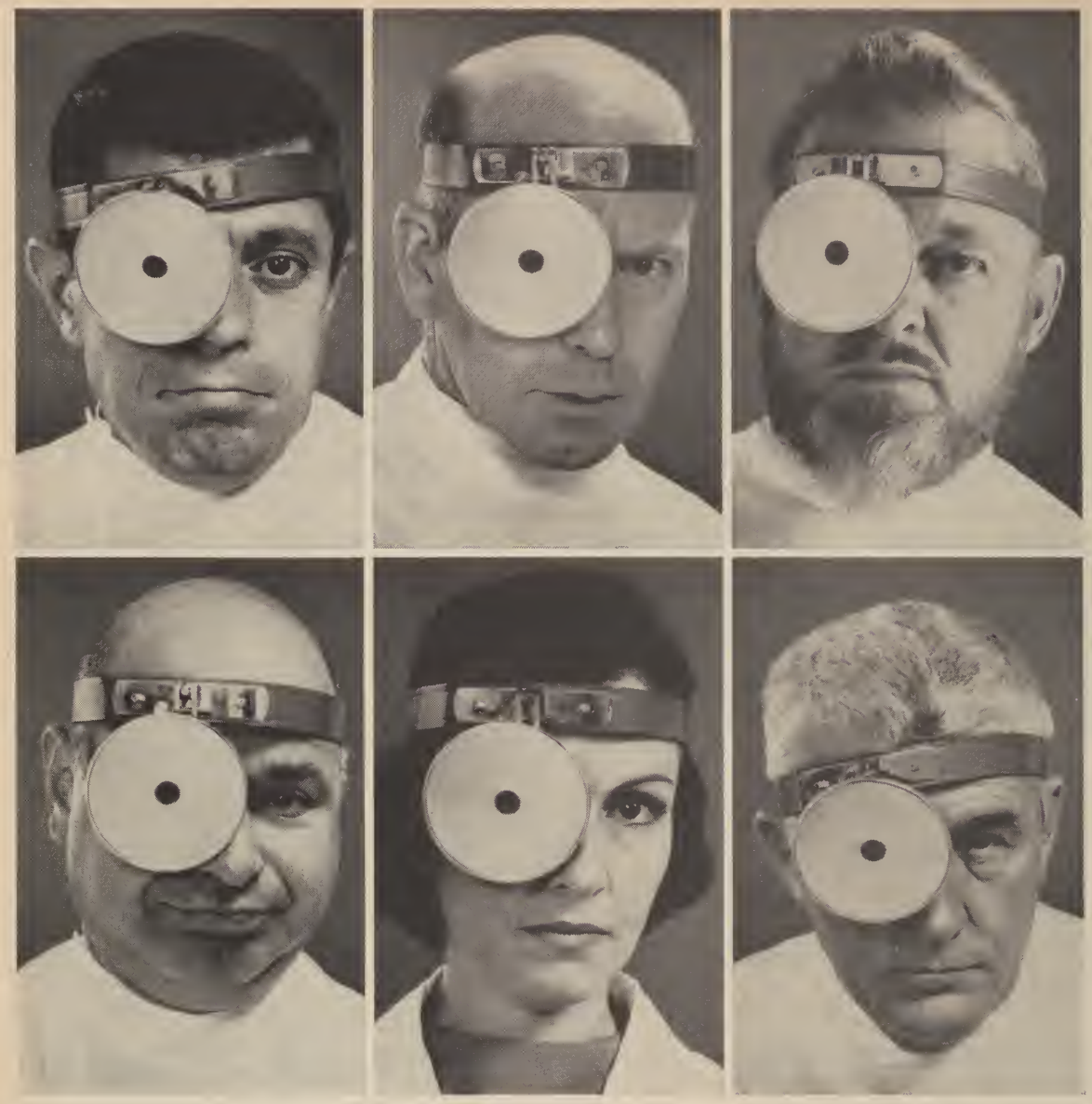
Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-170



"All Otolaryngologists are Alike"

Just look at them and you can see how much they have in common. Besides, they all go through pretty much the same training, and pass the same kinds of tests, and measure up to the same sort of standards. Therefore, all otolaryngologists are alike. Right?

Wrong! But that's no more preposterous than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more exacting. In fact, there are at least nine *specific differences* involving moisture content, purity, potency and speed of tablet disintegration, which make the manufacture of Bayer® Aspirin so different.

These Bayer standards result in significant product benefits, including gentleness to the stomach and product stability, that enable Bayer Aspirin tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that *all* aspirin tablets are alike, you can say, with confidence, that "it just isn't so."

You might also say that all otolaryngologists aren't alike, either.





PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Bibliographies

The library staff spends a good part of its time in literature search, and compilation of bibliographies. In order that all physicians may know what is currently being produced, each month we will list those bibliographies completed during the period since the last MSMJ appeared. Recently, bibliographies have been completed on the following subjects:

1. Acne
2. Birth control in foreign countries
3. Emergency room management
4. Fees
5. Mononucleosis, Infectious
6. Multiple sclerosis
7. Ozone—Toxicity
8. Pancreatic hormones—Physiologic effects
9. Pregnancy and diabetes
10. Silicosis
11. Thoracic cannulation

Copies of these bibliographies will be sent to any physician or library requesting them.

* * * * *

Did you visit the library exhibit at the Annual Meeting?

* * * * *

NEW ACCESSIONS—BOOKS
(Arranged by author and title)

Ackerman, Lauren Vedder
Surgical pathology. 4th edition. St. Louis, Mosby, 1968.

Alcohol, alcoholism and crime, a conference at Chatham, Mass., June 6-8, 1962, sponsored by the Massachusetts Department of Correction, Massachusetts Department of Mental Health, Massachusetts Department of Public Health . . . and the National Institute of Mental Health, 1962.

Allen, Arthur Charles
The skin; a clinicopathological treatise. 2d. ed. New York, Grune & Stratton, 1967.

American Association of Genito-Urinary Surgeons.
Transactions. V. 60 Dallas, Texas, The Association, 1968.

American library directory; a classified list of libraries, with names of librarians and statistical data, 1968-69. New York, R. R. Bowker, 1969.

American Medical Association.
Distribution of physicians, hospitals, and hospital beds in the U.S. 1967. Chicago, American Medical Association, 1967.

American Medical Association. Committee on Medicolegal Problems.
Alcohol and the impaired driver . . . Chicago, American Medical Association, 1968.

Baltimore City Health Department.
Annual report of the Department of Health, 153rd, Baltimore, 1967.

Bergman, Harry
The ureter. New York, Hoeber Medical Division, Harper & Row, 1967.

Collins, R. Douglas
Illustrated manual of laboratory diagnosis. Philadelphia, Lippincott, 1968.

Cowdry's arteriosclerosis. 2d. ed. Springfield, Ill., Thomas, 1967.

Davidson, Sir Leybourne Stanley Patrick
The prineiples and praetiee of medicine . . . 9th ed. Baltimore, Williams & Wilkins, 1968.

Duffy, John C.
The emotional health of physieians. Springfield, Illinois, Thomas, 1967.

Friedman, Arnold P.
Headaehes in ehildren. Springfield, Illinois, Thomas, 1967.

Hartford. Institute of Living.
Annual Report. 144th. Hartford, Connecticut, 1968.

Heardman, Helen
Relaxation and exereise for natural ehildbirth. 3rd. ed. rev. and re-edited. Edinburg, Livingstone, 1966.

Hospital Counеil of Maryland, Inc.
Directory. Towson, Maryland, 1968/69.

Institute Oswaldo Cruz, Rio de Janeiro.
Catalogo de periodicos da biblioteca do Instituto Oswaldo Cruz. Rio de Janeiro, 1963.

International Congress for Hypnosis and Psychosomatic Medicine, Paris, 1965.
Hypnosis and psyehosomatie medieine: proceedings. Jean Lassner, ed. Berlin, New York, Springer-Verlag, 1967.

Kellogg (W. K.) Foundation
Report, year ending Aug. 31, 1968. Battle Creek, Michigan, 1968.

Kessler, Edward
Diabetic acidosis; a programmed course of instruction. Philadelphia, F. A. Davis Co., 1967.

Kovar, Mary Grace
Charges for eare in institutions for the aged and chronically ill, U. S. May-June 1964. Washington, U. S. Dept. of Health, Education and Welfare, 1967.

Kraetzer, Arthur Furman
Procedure in examination of the lungs, with special reference to the diagnosis of tuberculosis. 3rd. ed. rev. . . . New York, Oxford University Press, 1947.

Lasagna, Louis
Clinieal pharmaeology. 1st. ed., Oxford, New York, Pergamon Press, 1966.

Lin-Fu, Jane S.
Lead poisoning in ehildren. Washington, U. S. Children's Bureau, 1967.

Lowell, Juliet
Dear doetor. New, enl. and unexpurgated ed. New York, Funk & Wagnalls, 1968.

Lyden, Fremont J.
The training of good physieians; critical factors in career choices. Cambridge, Mass., Harvard University Press, 1968.

Maickel, Roger P.
Bioehemical faetors in aleoholism. 1st ed., Oxford, New York, Pergamon Press, 1967.

Maryland Commission to Study Problems of Drug Addiction.
Interim report. Baltimore, Maryland Commission to study problems of drug addiction, 1966.

Maryland Commission to Study Problems of Drug Addiction.
Interim report, rev. ed., Baltimore, Maryland Commission to Study Problems of Drug Addiction, 1967.

Maryland Commission to Study Problems of Drug Addiction.
Interim report, Dec. 1967, Baltimore, Maryland Commission to Study Problems of Drug Addiction, 1968.

Maryland Historical Society
The manuscript collections of the Maryland Historical Society. Baltimore, 1968.

Maryland. Regional Planning Council
Regional health bibliography. Baltimore, Regional Planning Council, 1968.

Medical examination review book.
Comprehensive clinical, 2000 multiple choice questions and answers referenced to textbooks. 2d. ed. Flushing, N. Y., Medical Examination Publishing Co., 1968.

Menendez, Charles V.
Ulcers of the leg; cause and treatment. Springfield, Illinois, Thomas, 1967.

National Advisory Cancer Council.
Progress against cancer. Washington, U. S. Dept. of Health, Education, and Welfare, 1967.

Nelson, Arne B.
Chronic illness among residents of nursing and personal care homes. Washington, U. S. Dept. of Health, Education, and Welfare, 1967.

New England Medical Center Hospitals of the Tufts—New England Medical Center. Annual Report 1966/67.

Northeast State Conference on the Key Issues in the Prevention of Alcoholism, Pittsburgh, 1962, sponsored by the Pennsylvania Dept. of Health, Pennsylvania Dept. of Welfare . . . and the U. S. Public Health Service. Pennsylvania Dept. of Health, Harrisburg, 1963.

Pack, George Thomas
Treatment of cancer and allied diseases. V. 9. **Lymphomas and Related Diseases.** New York, Hoeber, 1964.

Parker Publishing Company Editorial Staff.
Secretary's desk book. West Nyack, N. Y., Parker Publishing Co., 1965.

Paschkis, Karl E.
Clinical endocrinology. 3d. ed. New York, Hoeber Medical Division, Harper & Row, 1967.

Physicians' desk reference to pharmaceutical specialties and biologicals . . . 23rd ed. 1969.

Quiring, Daniel Paul
The head, neck, and trunk; muscles and motor points. 3d. ed., rev. Philadelphia, Lea & Febiger, 1967.

Renal hypertension, edited by Irvin H. Page and James W. McCubbin. Chicago, Year Book Medical Publishers, 1968.

Reynolds, Frank Walker
Adult health; services for the chronically ill and aged. New York, Macmillan, 1967.

Rheumatology; an annual review. v. 1—
New York, American Elsevier Publishing Company.

Roaf, Robert
Scoliosis. London, E. & S. Livingstone, 1966. Distributed by Williams & Wilkins.

Southern surgical association.
Transactions. V. 79. Philadelphia, Lippincott, 1967.

Steinhart, Sydnae
Bibliography of the early works on arthritis. Baltimore, Welch Medical Library, 1968.

Symposium on Electrical Activity and Innervation of Blood Vessels, Cambridge, England, 1966.
Symposium on Electrical Activity and innervation of Blood Vessels; papers. Held in association with the 4th European Conference on Microcirculation, Cambridge, England, 1966. W. R. Keatinge, ed. Basel, New York, S. Karger, 1967.

Symposium on Reproduction, Pécs, Hungary, 1967. Symposium on Reproduction; papers. K. Lissak, ed. Budapest, Akadémiai Kiadó, 1967.

Thomson, Thomas J.
Postgraduate gastroenterology, the proceedings of a conference held in Glasgow, December 1-3, 1965, under the auspices of the Glasgow Postgraduate Medical Board. London, Bailliere, 1966.

Umber, Friedrich
Ernährung und stoffwechselkrankheiten, 2., neaubearb aufl. Berlin, Urban and Schwarzenberg, 1914.

U. S. National Communicable Disease Center. Training bulletin, 1968/69. Atlanta, 1969.

U. S. Public Health Service. National Center for Urban and Industrial Health.
Solid waste/disease relationships. Report by Thrift G. Hanks. Cincinnati, U. S. Department of Health, Education, and Welfare, 1967.

U. S. Social Security Administration Office of Research and Statistics.
Social security programs throughout the world, 1967. Washington, U. S. Department of Health, Education, & Welfare, 1967.

The Walking patient: a study in outpatient care: a study in outpatient care by Marvin B. Sussman and others. Cleveland, Press of Western Reserve University, 1967.

Warrick, C. K.
Anatomy and physiology for radiographers. 2nd. ed. London, Edward Arnold, 1966.

Weale, Felix Ernest
An introduction to surgical haemodynamics. London, Lloyd-Luke, 1966.

Wound healing; a symposium based upon the Lister Centenary Scientific Meeting held in Glasgow, September, 1965. Boston, Little Brown, 1966.

The Year Book of cardiovascular medicine and surgery 1968. Chicago, Year Book Medical Publishers, 1968.

The Year Book of general surgery. 1968. Chicago, The Year Book Publishers, Inc. 1968.

The Year Book of pediatries. 1969. Chicago, The Year Book Publishers, Inc., 1969.

BRONCHIAL DISTRESS

mudrane®

Emphysema, Chronic Bronchitis and Asthma are relieved in fifteen minutes by the fast-disintegrating, uncoated Mudrane tablet.

Checkpoints:

DILATES THE BRONCHI
DRAINS THE MUCUS
SEDATES MILDLY
SUSTAINED ACTION
SUPERIOR TOLERANCE

Each tablet contains:

POTASSIUM IODIDE	195 mg.
AMINOPHYLLINE	130 mg.
PHENOBARBITAL, Caution: may be habit forming.	21 mg.
EPHEDRINE HCl	16 mg.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

Precautions: Usual for aminophylline-ephedrine-phenobarbital. Iodides may cause nausea, long use may cause goiter. Discontinue if symptoms of iodism develop. Iodide contraindications: tuberculosis, pregnancy.

DOSAGE: One tablet, with full glass of water, 3 or 4 times daily.

Dispensed in bottles of 100 and 1000 tablets.

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Baltimore's most unusual dining place!

Famous **Owl Room**

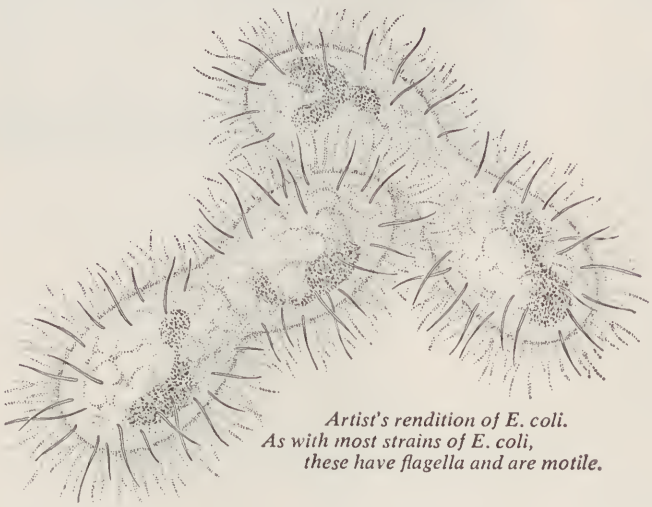


Belvedere Hotel
Charles & Chase Streets

mudrane®

BRONCHIAL DISTRESS

To help avert chronicity in acute cystitis



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

Although it may coexist wit chronic pyelonephritis or prosta titis, many cases of chronic cyst tis may result from incomplet treatment of a simple, acute cyst tis. For this reason, it is bein increasingly recommended tha appropriate antibacterial therap in full dosage be maintained fo up to two weeks or longer.

Most frequently, the dominan pathogen is gram-negative, usu ally *E. coli;* most often, you wil find Gantanol® (sulfamethox azole) effective against *E. co* and other sensitive organisms– gram-positive and gram-negativ —commonly seen in cystitis an other urinary tract infections Wide clinical usage of Gantanc has confirmed the efficacy of thi wide-spectrum antimicrobia agent in the treatment of cystitis

The rapidity of bacterial mul tiplication in a favorable urinar environment is well known Prompt control of acute bladde infection is therefore essentia

---

Before prescribing, please consult com plete product information, a summary o which follows:

Indications: Acute and chronic urinar tract, respiratory and soft tissue infec tions due to susceptible microorganisms prophylactically following diagnostic ir strumental procedures on genitourinar tract.

Contraindicated in sulfonamide-sensitiv patients, pregnant females at term, pre mature infants, or newborn infants dur ing first 3 months of life.

Warnings: Use only after critical ap praisal in patients with liver or rena damage, urinary obstruction or bloo dyscrasias. Deaths reported from hy persensitivity reactions, Stevens-Johnso syndrome, agranulocytosis, aplastic ane mia and other blood dyscrasias. In closely intermittent or prolonged therapy, bloo counts and liver and kidney function test should be performed. Clinical data insuf ficient on prolonged or recurrent therapy in chronic renal diseases of children un der 6 years.

Precautions: Occasional failures may oc cur due to resistant microorganisms. No effective in virus and rickettsial infec tions. Sulfonamides not recommende

not only to reduce the patient's discomfort but to prevent chronicity and possible ascending infection.

Gantanol (sulfamethoxazole) provides antibacterial activity within two hours of the initial 2-Gm dose, and subsequent 1-Gm doses, taken morning and evening, maintain therapeutic blood and urine levels lasting up to 12 hours. Significant symptomatic response is frequently achieved within 24 to 48 hours in acute, uncomplicated cystitis and other responsive urinary tract infections. In addition, Gantanol is usually well tolerated. Should prolonged therapy be required, the convenient *b.i.d.* dosage helps to minimize the problem of skipped doses.

Over eight years' clinical use has thoroughly demonstrated the qualities that make Gantanol a good choice for initial therapy of most urinary tract infections, including acute cystitis.

---

for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

Gantanol®
(sulfamethoxazole)
assures rapid, sustained, antibacterial activity with b.i.d. dosage

Gantanol® B.I.D.
(sulfamethoxazole)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

CANNIBALISM IN THE CURRICULUM?

Some years ago, a professor at the University of Michigan published the results of his experiments with planaria. Flatworms that had been trained to gather in groups when exposed to the light of a lamp were ground up into a broth that was then fed to untrained planaria. The remarkable outcome was that the untrained worms responded to the same stimulus in the same way.

Subsequent experiments by other investigators have shown that similar results, using brain and liver extracts, could be demonstrated in rats, mice and hamsters. Not only this, but it seems possible, by injecting an enzyme that destroys RNA (ribonucleic acid), to reduce the capacity of these animals to learn. The belief of many cannibal tribes that eating the flesh of their brave enemies transfers their courage to the ingester thus seems to receive scientific confirmation.

Unfortunately, many other experimenters have not been able to duplicate these results. The day when medical students can be aided in their understanding of the fantastic biochemistry of our brave new world by eating the ground-up brains or livers of their professors is still only a remote possibility. Isn't science wonderful!

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545

—The lowest priced tetracycline—nystatin combination available—



Gastrointestinal Disorders are a Challenge to Insurance Underwriters

A panel of life insurance medical directors agreed recently that common diseases and disorders of man may be more significant than first realized and may offer some of the most challenging problems to the life insurance underwriter.

Impairments such as peptic ulcer, polyps, vertigo and hiatal hernia are often encountered, the panel agreed, and may develop, or be part of, a more serious condition leading to increased mortality. The panel presentation was part of the annual meeting of the Association of Life Insurance Medical Directors of America in St. Louis in October.

The frequency of a peptic ulcer in at least 12% of the population, a panel member said, emphasizes the possibility of complications that could lead to increased mortality.

He told the medical directors that underwriting problems most often occur in "differential diagnosis," and when a decision is made on incomplete or questionable information.

The industry is "very dependent" upon attending physicians when underwriting most gastrointestinal disorders, since the insurance examination provides few significant findings.

STATE-SUN FEDERAL

Savings & Loan Association

with locations at

809 N. HOWARD ST. 728-4640

and

8200 HARFORD RD. 668-1400

MORTGAGE LOANS • CONSTRUCTION LOANS

High Quarterly Dividends: Paid March 31, June 30, September 30 and December 31

Savings Received on or Before the 10th
Receive Dividends from the 1st

Member: Federal Savings & Loan Insurance Corporation, an instrumentality of the U.S. Gov't; Federal Home Loan Bank

SAVINGS INSURED UP TO $15,000

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected for possible growth of principal and income.

NO SALES CHARGE

NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

F.T.D.

Geo. RADEBAUGH *& Sons*

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300

The Name

We have now completed our quadrennial balloting for national leadership. Physicians, no doubt, rank high in percentage of voters as compared to other occupational groups. The news media have brought into focus several ground swells in connection with this close election. Both conventions seemed to have lost personal involvement with the voter. Most recent figures show the total popular presidential vote to have been some five million less than that predicted. Some evidently feel the issues were not sharply defined enough by the parties. A vocal minority unsuccessfully attempted to disrupt the entire system. But even this attempt at disruption, this continual confusion by heckling, this negation of all candidates and their programs, this movement toward anarchy, even the nomination of a pig for president, if you will, represents, by its very opposition to the system, partial participation in it.

Nonparticipants

How many of us, disappointed with issue clarification and both candidates, did not participate in the voting? The number of physicians in this category will never be exactly known, and the figure is not important. For those who did not feel that a choice could be made and, therefore, cast no presidential vote, that is their right. But not to vote implies acceptance of the winner, whoever he might be. Thus, until the next election, these individuals should not complain of any national

STERLING LIGHTING CO.

DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY



We Repair and make Lamps
"Lamps make the home Beautiful"
LE 9-0222 403 N. Charles Street
Baltimore, Md. 21201

of the Game

policy or direction unless prefaced by the fact that they were not participants, merely observers.

An analogous situation confronts the medical profession. The system has provided us with a leadership and policy-making organization, the American Medical Association. There is no lack of individual medical voices to be heard in criticism of this body. But how many of these voices are members of the AMA, much less active participants in its workings? Do they belong to local state and national societies? Do they attend their meetings? Do they accept hard-working committee memberships? Do they verbalize their complaints at organization meetings?

For those of us whose answer is "no" to the above questions, and who have great differences with the structure and policy of the AMA, the proper appellation is nonparticipant. We are less participatory than if we let our hair grow, stopped washing, picketed and disrupted meetings, and even nominated animals for high office.

The voluntary nonparticipant, then, should hold his tongue as firmly in regard to the AMA as to the national political scene. If the stimulus to speak out is strong enough, dissatisfaction acute enough, and commitment to ideas deep enough, then let him pay the admission price of vocal criticism: active membership in the organization. Nonparticipation implies acceptance.

The rules of the game are known as democracy. The name of the game is participation.

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

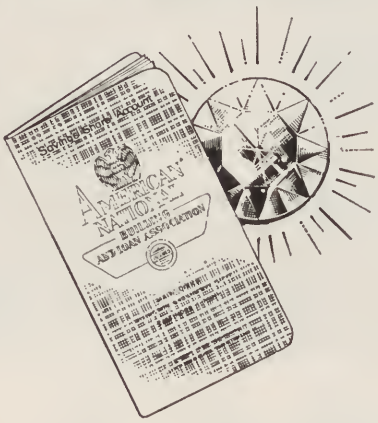
Prompt Pick-up and Delivery

MU 5-3232

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202

The G-E-M of a Plan Brings You Big Rewards 4 Times Yearly:

Dividends Now Paid Quarterly!



Every season is an added reason to save at American National: you'll be rewarded for your foresight *four times a year,* with dividends payable February 1st, May 1st, August 1st, and November 1st. Thus our GEM of a Plan does even greater things for you!

Here, you Gain Every Month and *keep what you gain,* because we continue to calculate your dividends on a MONTHLY BASIS. Even if you withdraw part of your funds, you still receive the dividends of previous months, just by keeping your account open with a balance of $10 or more. ★ Come and open your account now—or write to us and save-by-mail!

ACCOUNTS INSURED UP TO $15,000 BY AN AGENCY OF THE U. S. GOV'T.

American National
BUILDING & LOAN ASSN.
LEXINGTON AND LIBERTY STS., BALTIMORE
TOWSON PLAZA • PERRY HALL • FALLSTAFF
HARUNDALE MALL • WESTVIEW

Funds Received by 10th of the Month Earn Dividends for the Entire Month

Accounts Insured up to $15,000 by an Agency of the U.S. Government

Pay 'Phone or Gas & Electric Bills at Any Office. Money Orders and Travelers' Checks Available



SLEEP ZONE

To turn a hospital zone into a sleep zone, you need more than peace and quiet. Your patients need a mattress which gives the right kind of firm, comfortable support. To hospitals across the country, this means the Serta Perfect Sleeper "Hospital" mattress.

It provides restful, healthful sleep, because the patient sleeps **on** it, not in it. And just as important to you, the Serta Perfect Sleeper retains its firmness for years and years of service.

Interested? There's a Serta contract bedding expert near you. Let him help you choose from the comprehensive range of specifications on Serta quality bedding.

SERTA

CONTRACT DEPARTMENT
8415 Ardmore Road
Landover, Md.
322-1000
BALTIMORE—PL 2-2087

Words to go to sleep by
PERFECT SLEEPER® MATTRESS
Serta

DOCTORS' OFFICES

LARGE
MEDIUM
SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST.

CORPORATION

11 E. Chase St.
Phone 539-8553



For the Best in Leisure Living

Enjoy a vacation at the

Atlantic Sands
MOTEL

Boardwalk and Baltimore Ave.

REHOBOTH BEACH, DELAWARE

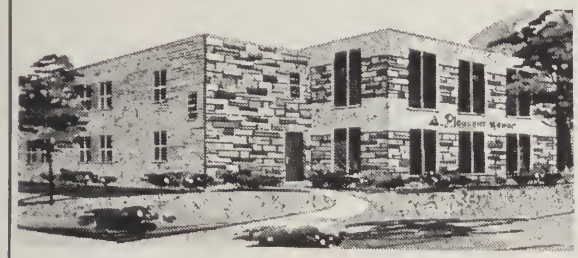
- 80 FINE ROOMS
- AIR CONDITIONED
- TELEVISION
- BEACH SHOP
- HEATED POOL
- TELEPHONE SERVICE
- RESTAURANT
- ELEVATOR SERVICE

OPEN ALL YEAR LONG!

Write for Reservations . . . . . or

Phone **(302) 227-2511**

"The Best of Care
for Those You Love"



Pleasant Manor
CONVALESCENT AND NURSING CENTER

ONE OF THE NEWEST, MOST MODERN
PARA-MEDICAL FACILITIES

Round-the-clock care by Professional Staff
Complete Intensive Care Units
Physical and Occupational Therapy

Excellent Meals--Kosher Food on Request
Air-Conditioned, Fire-resistant Building
Centrally Located Near Sinai Hospital
Your Inspection Invited

4615 PARK HEIGHTS AVE.
BALTIMORE, MD. 542-4800

Growing Feet Can
Have Problems!



PRONATION KNOCK-KNEES PIGEON-TOES

These common problems can be helped
with proper shoes, correctly fitted.

Prescriptions Carefully Filled

VAN DYKE & BACON

307 N. Charles St. SAratoga 7-3775
5849 York Rd. IDlewood 3-1100
Baltimore, Maryland

Fellowship Opportunities

Fellowship in Clinical Applications of Radioisotopes

The Division of Nuclear Medicine of the Stanford University Department of Radiology invites applications for a one-year or two-year fellowship in clinical applications of radioisotopes. The program includes training in isotope methodology and instrumentation as well as clinical and research experience and is designed for those with a special interest in nuclear medicine or oncology.

Openings are now available for July 1 and September 1, 1969. Applicants must have completed two years of postgraduate resident training. The salary is $9,000 a year.

Further information may be obtained from Joseph P. Kriss, MD, Professor of Medicine and Radiology, Nuclear Medicine Division, Stanford University Hospital, Stanford, California 94304.

Training Program in Gastroenterology

A clinical and research fellowship program in gastroenterology will be initiated on July 1, 1969, by the gastrointestinal and nutrition unit of the Department of Medicine of Montefiore Hospital (500-bed general hospital) and the University of Pittsburgh School of Medicine. The unit, which is staffed by five gastroenterologists, is under direction of a full-time faculty.

The fellowship will include care for the patients seen in the gastrointestinal clinic and consultations for the ward and private patients.

Further information may be obtained from Siamak A. Abidi, MD, PhD, Department of Medicine, Montefiore Hospital, Pittsburgh, Pennsylvania 15213.

MEDICAL CENTER

to be built in

THRIVING SHOPPING CENTER

at

PERRING PARKWAY and McLEAN BLVD.

● All suites on ground floor ●

For information . . . . call

W. C. PINKARD & CO.

5 E. REDWOOD ST. BALTIMORE, MD.

PL 2-4285

Achromycin V
250 mg. Capsules

ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481C-9

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ **INGLESIDE SHOPPING CENTER**
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ **HILLENDALE SHOPPING CENTER**
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

HOOD CONVALESCENT HOME

"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF

CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED

National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM

Certificate Holder—Baltimore County
Fire Prevention Bureau Award

LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800

5313 EDMONDSON AVE.



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth

Classified Advertising

POSITIONS AVAILABLE

ANESTHESIOLOGIST WANTED—Board eligible or certified. Fee for service. Practice in 300-bed general Hospital. Send resume to: Box #6, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

PHYSICIAN FOR INDUSTRIAL CLINIC—July 1, 1996 or sooner. Excel. opp. Starting salary $22,000. Profit-sharing plan after 1st yr. Partnership if desired. Contact: Maxwell Hurston, MD, 919 18th St., NW, Washington, D.C. 20006.

PEDIATRICIAN—Brd. cert. or eligible to associate with busy fellow practitioner in pleasant suburban Md. area. Salary or percentage if previous experience. Send resume to: Santiago L. Garza, MD, 4302 St. Barnabas Rd. SE, Washington, D.C. 20031.

GP PARTNERSHIP—Percentage or salary. Retiring in 2-3 years. Two-man office. Not doing hospital work, but open staff hospitals available. Good country. Congenial people. Professional and personal data requested. Send reply to: Box #9, c/o JOURNAL, 1211 Cathedral St., Balto., MD. 21201.

DERMATOLOGIST—To complete thriving medical clinic in Brooklyn Park-Linthicum area. If interested call: 789-7100.

PHYSICIAN FOR EVALUATION CLINIC—University of Maryland Hospital, 3-5 mornings a week. Prefer physician under 55 years of age. Contact: William L. Stewart, MD, 955-8242.

PHYSICIANS, SURGEONS, GENERAL PRACTITIONERS or ORTHOPODS—For industrial clinic. Starting salary $18,000 plus bonus and other benefits. Excellent opportunity for permanent career and partnership in group practice in this field. Reply giving training, experience and hospital affiliation to: W. J. Hindman & Associates, 3506 Offutt Rd., Randallstown, Md. 21133.

POSITIONS WANTED

ANESTHESIOLOGIST—39, Board qual, Md. Lic. Seeks relocation in Md.—Balto-Wash are pref. Partnership, assoc., fee for serv, part time and assoc. with GP or other. Reply (confidential): W. Accomando, 485 Eisenhauer Court, Wyckoff, N.J.

RADIOLOGIST—University trained, Board certified in Diagnosis, Therapy, and Isotopes. Desires Locum Tenans during summer. Write: Box #11, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

FOR SALE

PHYSICIAN'S HOME & OFFICE—Two buildings of stone construction with slate roofs. Each building individually maintained with central heating and a/c. Two bedroom home. Office has large waiting room, 2 exam-consultation rooms, 2 bathrooms. Buildings connected by a breezeway and porch, enclosure—could be converted for other uses. Structures occupy one acre, center of a block on Liberty Rd, near Beltway Exit 18. Call: 653-6565 anytime.

FOR RENT

PROFESSIONAL OFFICES—3501 Fait Ave, East Balto. Established medical practice (20 yrs). Opening for ophthalmologist, radiologist, otolaryngologist, dermatologist or dentist. Call: 866-8924 anytime.

CLASSIFIED ADVERTISING

Effective May 1, 1963

$1.50 per line per insertion

Count seven average words to each line. Add one line if box number is desired.

Members of the Medical and Chirurgical Faculty shall be entitled to one complimentary insertion in any twelve-month period. Widows of members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment.

MARYLAND STATE MEDICAL JOURNAL
1211 Cathedral St., Baltimore, Md. 21201

Advertisers in This Issue

A & F Nurses Registry 18
Aids for Hearing, Inc. 38
Al-Lin Ambulance Service 96
American National Building & Loan Assoc. 129
Ann-Lee Laboratories, Inc. 10
Arundel Federal Savings & Loan Assoc. 118
Atlantic Sands Motel 130
Baltimore Nurses Exchange, Alice Weber 30
Baltimore Oxygen Supply Co., Inc. 10
Belvedere Hotel 123
Bolton Hill Dinner Theatre 28
Bristol Laboratories 11
Broadview Restaurant 37
Burroughs Wellcome & Co., Inc. 114
Capital Savings & Loan Assoc. 10
Oscar Caplan & Sons 12
Chesapeake Rug & Drapery Cleaners 118
Club Venus 37
Cobb-Woods Services 10
Computer Center, Inc. 16
Cork 'n Bottle Restaurant 37
Herbert Cox—Correct Shoes 118
Dobbs House Restaurant 37
Doctors Supply Co. 28
Eastern Overall Div. Rentex Services Corp. 9
Eleven East Chase St. Corp. 130
Evangelical Press 8
Fedder's Medical Services 12
Federated Business Services, Inc. 30
Fields Pharmacy 96
Franklin Uniform Co. 107
Geigy Pharmaceuticals 20-22
Glenbrook Laboratories 120
Globetrotter Travel Agency 110
Hecht Co. Northwood Rooftop Restaurant 37
Hidden Brook 18
High Fidelity House 38
Highland Hospital 38
Hilton Nursing Home ..... 3rd Cover
Hood Convalescent Home 132
House in the Pines Nursing Homes 116
Humble Leasing Co. 104
Hynson, Wescott & Dunning, Inc. 1
International Pharmaceutical Corp. 86-87
Lederle Laboratories 3, 8, 33-34, 102, 126, 132
Eli Lilly & Co. 4
Lucas Design Group 110
Maico Hearing Aids, Inc. 126
Maria's 300 Restaurant 37
Mercantile-Safe Deposit & Trust Co. 43
Miller Brothers Restaurant 37
Milton Inn 37
Monarch Lincoln Mercury, Inc. 104
Murray-Baumgartner Surg. Instr. Co., Inc. 15
Palmer House 37
Parke, Davis & Co. 91
Pfizer Laboratories 44-45
Pielke Landscape Services 110
W. C. Pinkard & Co. 132
Pitman-Moore 94-95
Pleasant Manor Nursing Home 131
Wm. P. Poythress & Co., Inc. 123
T. Rowe Price Growth Stock Fund, Inc. 127
Professional Management Co. 15
Geo. Radebaugh & Sons 128
Read's Drug Stores 132
R & H Motors, Inc. 110
Katherine Robb Nursing Home 81
A. H. Robins Co. 23-24, 32, 111
Roche Laboratories ..... 112-113, 124-125, 4th Cover
Russell, Marsh & Kennedy, Inc. 99
Sandoz Pharmaceuticals 119
Manuel Schwartz, Hearing Rehab. 85
G. D. Searle & Co. 40-41
Security House, Inc. 35
Serta Mattresses 130
Skill Surgical, Inc. 110
Special Diet Shop 81
State-Sun Federal Savings & Loan Assoc. 127
Sterling Lighting Co. 128
Strasenburgh Laboratories 42
Stuart 19
Mano Swartz—Furs 12
Taylor Manor Hospital ..... 2nd Cover
Tijuana Tacos 37
Valley Mart 10
Van Dyke & Bacon—Shoes 131
D. Stuart Webb Advertising Services, Inc. 129
Westview Lounge & Supper Club 37
White Rice Inn 37
Winthrop Laboratories 39
Wyeth Laboratories 92-93, 133
Zimmermann's Shoes 12

Schools teach your kids how to read and write.

We teach them how to save lives.



help us help

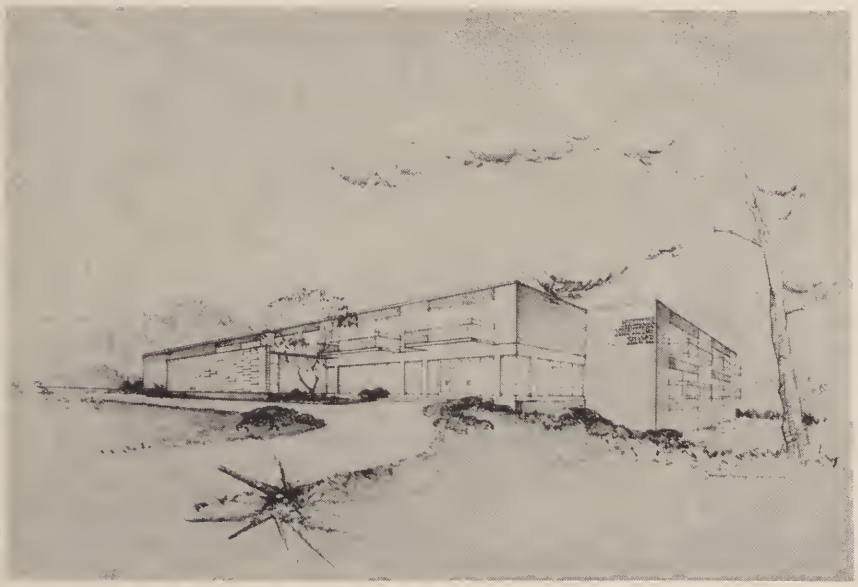
The American Red Cross.
We don't know where
we'll be needed next.

You don't either.

advertising contributed for the public good

ADVERTISING COUNCIL

Opening 1969



HILTON NURSING HOME

3313 Poplar Street, corner of Hilton

4 blocks south of North Ave. & Hilton St.

BALTIMORE

Now being built—a superb new 104-bed facility, the last word in pleasant living and competent care for the aged, ill or convalescent. Embodying the highest standards and the most advanced equipment and luxurious furnishings, it will meet your most exacting requirements.

Modern, air-conditioned and fire-safe building

Finest facilities for comfort and health care

104 beds, all in private and semi-private rooms—no wards or dormitories

Registered nurses 24 hours a day

For advance information . . . . phone

426-3104

Symbols in a life of psychic tension

B.A.
cum laude

V.P.
at thirty-two

ECG
and complete examination normal
(persistent palpitations)



Valium®
(diazepam)

for reliable relief of psychic tension and associated somatic and depressive symptoms (including tension-induced insomnia)... usually well tolerated... 2-mg, 5-mg or 10-mg tablets *t.i.d.* and *h.s.*

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

W1
M4791
READING
ROOM
RECEIVED
MAY 2 8 1969
National Library
of Medicine



Maryland State Medical Journal

FICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

VOLUME 18, NUMBER 5
MAY 1969

ORDER NO LJV
BETHESDA MD 20014
BOX 0

How much does illness and lost time cost you?

KEX FLOOR PLAN PACKAGE —SERVICED BY RENTEX— IS EFFECTIVE AGAINST INFECTIOUS GERMS!

Read this Important News Now: — The U.S. Dept. of Agriculture has accepted the following claims for KEX Services:

- "KEX" Walk-Off-Mats are chemically treated with an anti-microbial additive to inhibit the growth and spread of environmental bacteria in a mat and to reduce contamination in the areas serviced by Walk-Off-Mats.
- "KEX" Walk-Off-Mats are effective against Staph Aureus.
- "KEX" Walk-Off-Mats reduce populations of air and dust-borne Staph Aureus in the areas serviced by Walk-Off-Mats.
- "KEX" Walk-Off-Mats reduce the introduction of bacterial populations in rooms serviced by Walk-Off-Mats.

Help clean the air for you and your employees. Let your Rentex Service expert show you how to minimize air borne bacteria with KEX Services. Act Now — TODAY! Call CE. 3-5700.

RENTEX SERVICES CORP.

RENTEX EASTERN OVERALL DIVISION

2804 WILKENS AVE., BALTIMORE, MD. 21223 • CE 3-5700

EASTON, MARYLAND ALEXANDRIA, VA.

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

IN THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF PREMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

■ LUTREXIN, the non-steroid "uterine relaxing factor" has been found to be useful by many clinicians in controlling abnormal uterine activity.

■ Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

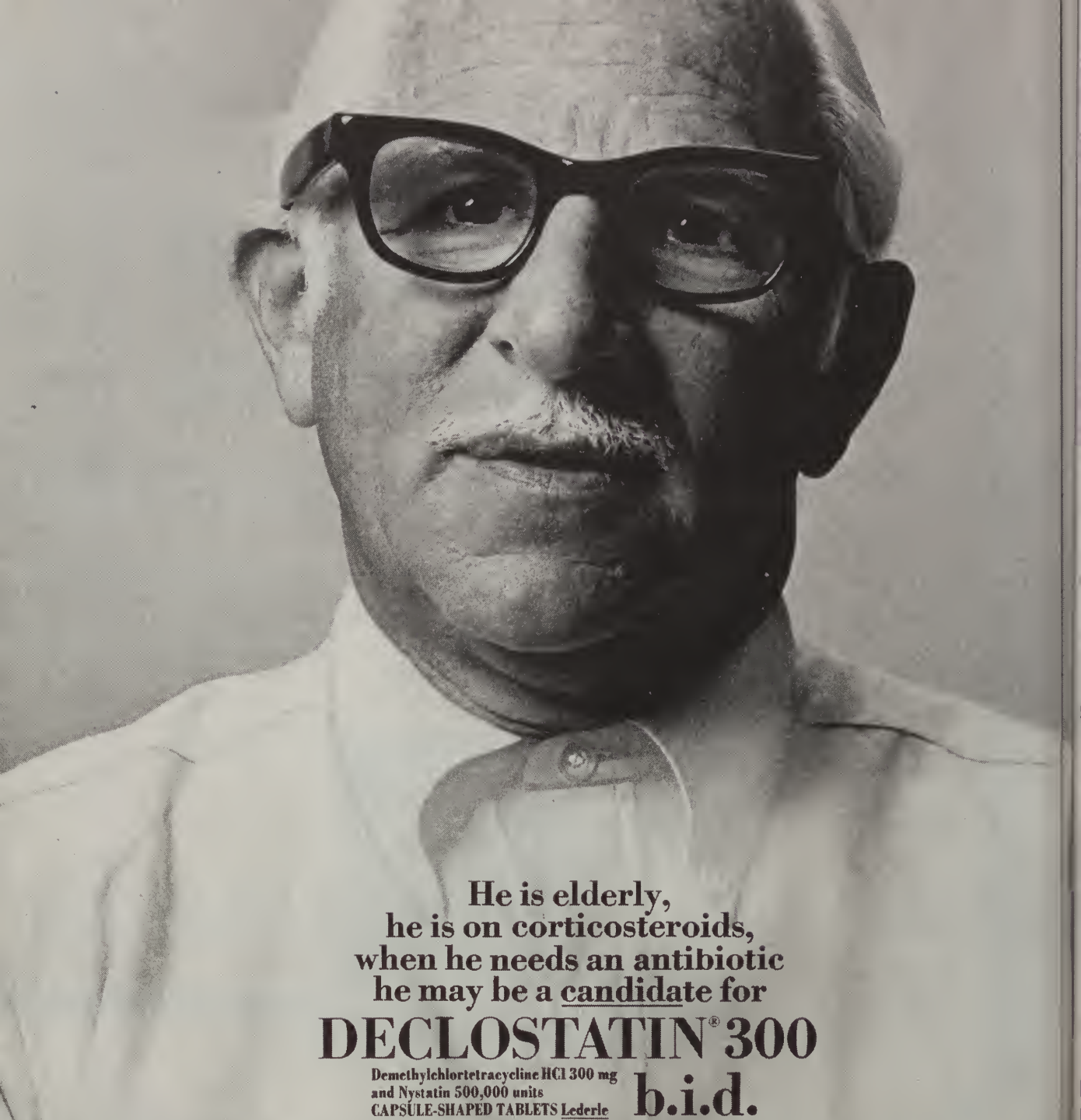
■ Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)



He is elderly, he is on corticosteroids, when he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, app measures should be taken.

In infants, increased intracranial pressure with bulging fonta been observed. All signs and symptoms have disappeared rapid cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomitir rhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—mac ular and erythematous rashes; a rare case of exfoliative dermat been reported. Photosensitivity; onycholysis and discoloration nails (rare). Kidney—rise in BUN, apparently dose related. T increase in urinary output, sometimes accompanied by thirst Hypersensitivity reactions—urticaria, angioneurotic edema, anap Teeth—dental staining (yellow-brown) in children of mothers gi drug during the latter half of pregnancy, and in children given t during the neonatal period, infancy and early childhood. Enam plasia has been seen in a few children. If adverse reaction or crasy occurs, discontinue medication and institute appropriate

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Sh given 1 hour before or 2 hours after meals, since absorption is i by the concomitant administration of high calcium content drug and some dairy products. Treatment of streptococcal infections continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES, A Division of American Cyanamid C Pearl River, New York

Maryland State
Medical Journal

VOLUME 18 MAY 1969 NUMBER 5

CONTENTS:

Editorial—What's In a Name? Jeanne B. Sargeant 59

Human Kidney Transplantation: Present Status and Projected Future, Bruce H. Stewart, MD, Ralph A. Straffon, MD 61
"Renal homotransplantation, although still developmental, has already proven to be an effective treatment for many patients dying of terminal renal failure. Patients receiving kidneys from living related donors can expect at least a 75% one-year survival rate; those receiving kidneys from non-living donors average about 50% one-year survival. . . ."

Renal Homotransplantation, Paul Bormel, MD 68
Although the transplantation of human organs appears to be a relatively recent innovation in the medical field, its concept dates back to the ancient mythology of Egypt, Greece, and Rome.

The Management of Behavior Disorders in the Geriatric Patient, John Spencer, MD 73
"Organic disease or dysfunction in the aged can often obscure the presence of mental or emotional disorder. The hostile or confused behavior of a geriatric patient who is hard of hearing, for example, is more likely to be attributed to his sensory deficiency than to underlying mental disorder."

Preliminary Report on the Dietary Management of Patients With Advanced Carcinoma, Barbara A. Solomon, MD, MA 77
"Frequently, the main problem concerning patients with terminal types of carcinoma is anorexia, nausea, and vomiting. In an attempt to counteract these symptoms, the resulting malnutrition, and weight loss in three cases of carcinoma, the following diet was devised."

Sarcoma Botryoides, H. Melvin Radman, MD 80
"Several years ago, unusual findings were reported in a patient with a huge abdominal mass. It was thought that the tumor was not associated with disease of the genital system, but rather represented an example of primary omental sarcoma. Most authorities would agree than an accurate clinical or pathological diagnosis is difficult in such an entity. Subsequent events proved the validity of this contention."

Postoperative Management of Infants, J. Alex Haller, MD 85
"As an area of special interest, pediatric surgery has developed primarily for two reasons, The first of these is the unique nature of congenital anomalies which occur in the newborn and which, if not recognized and immediately treated, will result in death of the baby, or a severely debilitated child. The second reason has been a gradual realization that the physiological responses of a baby are quantitatively and qualitatively different from an adult and that dramatic changes can occur with greater rapidity during the operative and postoperative care of an infant . . ."

DEPARTMENTS:

Library Page—Hewson on Blood 27
Your Medical Faculty at Work, John Sargeant 89
Baltimore City Health Department—Public Health and the Conquest of Disease in Baltimore, 1792-1968, Joseph Gordon 95
Maryland State Department of Mental Hygiene—The National Scene 98
Maryland State Department of Health—Measles Morbidity in Maryland 99
Traffic Safety—Drugs and Driving, Gerard D. Dobrzycki, MD 101
Rehabilitation Notes—Various Pain Syndromes Which May Result From Osteoarthritis of the Cervical Spine, Lee Riley, Jr., MD 103
Tuberculosis 107
Heart Page—Chronic Cor Pulmonale, David G. Simpson, MD 109
Pathology—Federal Action Against Pooled Plasma 113

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301). ©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland. Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

ON THE COVER: Although the outriggers pictured are being sailed in the Basilan Strait off the Southwest coast of Mindanao in the Philippines, similar models are becoming popular in the Chesapeake Bay, and other places along the eastern seaboard. (Photograph: courtesy of the Philippine Tourist and Travel Association, Inc.)

Doctors Take Note **5**
Executive Secretary's Newsletter **9**
Component Societies **13**
The Month in Washington **19**
Semiannual Meeting **23**
Letters To the Editor **25**
Library Accessions **28**
Serologic Syphilis Test **33**
Maryland Association of Medical Assistants **44**
Woman's Auxiliary **48**
Medical News **51**
How to Get Paid for Testing Military Patients **115**
Rising Mental Health Demands **123**
Tyson Street Open House **125**
AMA Surveys Group Practice **128**
Physicians Questioned on Heart Transplants **131**
Multiphasic Screening **133**
Resort Advertisers' Index **138**
Classified Advertising **140**
Advertising Index **141**
Information for Authors **142**

THE APRIL COVER REVEALED . . .

Due to a bit of controversy as to who is who and what regarding the couple depicted on the cover of the April Journal, we now reveal the original photograph.

The photograph was shot in Mount Vernon Place during the Flower Mart by Frank Spinek of the News American.

The Journal staff had quite innocent intentions, you see.

—the staff



Doctors take note...

MAY 16-18, 1969
PENNSYLVANIA SOCIETY OF ANESTHESIOLOGISTS

Annual Meeting: Holiday Inn, Gettysburg, Pa. Contact: Chairman of the Program Committee, Herbert D. Weintraub, MD, University of Pennsylvania Hospital, 3400 Spruce St., Philadelphia, Pa. 19104.

MAY 17, 1969
MARYLAND-D.C. SOCIETY OF ANESTHESIOLOGISTS

Symposium—Acute Respiratory Failure: Holiday Inn Downtown, Baltimore, Md. Contact: T. Crawford McAslan, MD, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201.

MAY 17-21, 1969
THE MEDICAL SOCIETY OF NEW JERSEY

203rd Annual Meeting: Haddon Hall, Atlantic City, N.J. Contact: The Medical Society of New Jersey, 315 West State St., Trenton, N.J. 08618.

MAY 19-22, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Adolescent Medicine; University of Washington School of Medicine, Seattle, Wash. Co-Directors: James W. Haviland, MD, FACP; S. L. Hammer, MD; John Lien, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MAY 19-23, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Intensive Care Units: New York University and St. Vincent's Hospital, New York, N.Y. Co-Directors: William J. Grace, MD, FACP, and John J. Gregory, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

MAY 20, 1969
UNIVERSITY OF MARYLAND HOSPITAL/DIVISION OF HYPERTENSION AND RENAL DISEASES

In-Hospital Conferences—Radioimmunoassay of Angiotension: 4 PM, University of Maryland Hospital, Psychiatric Institute, Room I-704, Baltimore, Md. 21201.

MAY 24-28, 1969
NEW YORK STATE ANNUAL HEALTH CONFERENCE

Sessions on various aspects of Environmental Health Problems: Lake Placid, N.Y. Participating is the State Action for Clean Air Committee. Contact: Newsletter, 105 East 22nd St., New York, N.Y. 10010.

MAY 26-28, 1969
COMMITTEE ON CONTINUING MEDICAL EDUCATION

Course—Medical Aspects of Radiological Health. This course includes demonstrations and laboratory exercises on patient protection, shielding and scattering of X-rays. Contact: John P. Adams, MD, Chairman, Committee on Continuing Medical Education, George Washington University Medical Center, 2150 Pennsylvania Ave., N.W., Washington, D.C. 20037.

JUNE 2, 1969
AMERICAN PSYCHIATRIC ASSOCIATION COMMITTEE ON PSYCHIATRY AND MEDICAL PRACTICE

International Conference on Drug Abuse: Americana Hotel, New York. The Conference will feature papers on various subjects including: national and international control of the traffic in narcotics and other dangerous drugs; treatment and rehabilitation of drug addicts; prevention of drug abuse. Contact: International Association for Accident and Traffic Medicine, 520 First Avenue, New York, N. Y. 10016.

JUNE 5-6, 1969
TECHNICON'S INTERNATIONAL CONGRESS ON AUTOMATED ANALYSIS

Two-day Symposium—Multiphasic, Biomedical Health Profiling and Population Screening: Chicago, Ill. Chairman: Morris Collen, MD, BEE. Symposium will consist of sessions on Pathology, Biostatistics, Populations and Non-Humans. Contact: Jerome E. Golin, Technicon Corporation, Tarrytown, New York, 10591, Tel. (914) 631-8000.

JUNE 9-13, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Internal Medicine: Clinical Application of Current Concepts: University of Cincinnati Medical Center, Cincinnati, Ohio. Co-Directors: Richard W. Vilter, MD, FACP, and James F. Schieve, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 11-14, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Neurology and the Internist: Bowman Gray School of Medicine, Winston-Salem, N. C. Director: James F. Toole, MD, FACP. Co-Director: Richard Janeway, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 16-20, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Hematology for Internists with Emphasis on Recent Advances: University of Rochester School of Medicine and Dentistry, Rochester, N. Y. Co-Directors: Robert I. Weed, MD, FACP; Stanley B. Troup, MD, FACP; and Lawrence E. Young, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 22-26, 1969
AIR POLLUTION CONTROL ASSOCIATION

62nd Annual Meeting: Americana Hotel, New York. Chairman: Austin N. Heller, Commissioner of Air Resources of New York city. Contact: Bill Oliver, Tel. (212) 686-4700 or Bill Farley, (212) 460-4111.

JUNE 23-26, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Valvular Heart Disease, The Basis For Selecting Treatment: University of Oregon Medical School, Portland, Oregon. Co-Directors: Herbert E. Griswold, MD, FACP, and Howard P. Lewis, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational aotivities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

CHARLES W. NEVILLE, JR., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—253-2761



Mano Swartz

The Label That Leaves No Doubt

Maryland's Exclusive Representative for *Oleg Cassini* Furs

Arrange now for safe and dependable fur storage at

Maryland's Oldest and Largest Furrier

225 N. HOWARD ST.
BALTIMORE

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.

Rings With Your Coat of Arms

CUSTOM CRAFTED

In our workshop we design and make rings of individuality, with your coat of arms or other design DEEPLY hand-engraved for sealing.

Estimates cheerfully given.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

Inexpensive Effective

CAMP



HEAD HALTER TRACTOR KIT

Recommended for traction treatment of:

1. Syndromes caused by slipped cervical discs.
2. Certain fractures of cervical vertebrae.
3. Certain types of tuberculosis of the spine, in preparation for, instead of or after fusion of the spine.
4. Certain cases of neck-muscle spasm.
5. Temporary measure until a cervical brace is prepared.

DONALD O. FEDDER, ORTHOTIST

Rents and Sells Hospital Equipment

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

executive secretary's newsletter

May, 1969

ANNUAL MEETING REGISTRATION

The 1969 Annual Meeting recorded the highest registration ever for the annual session of the Faculty. Registration totalled 1508. The breakdown is as follows:

Physicians	815
Residents & Interns	65
Medical Students, Technicians, Nurses & Other Allied Health Persons	362
Exhibitors	266

BLUE SHIELD REPORT

Maryland Medical Service, Inc., Maryland's Blue Shield plan, reported at its annual session that benefits paid on behalf of its members include:

$20.6 million to help cover the cost of 643,600 physician's services
$10.8 million in Part B, Medical Care benefits to those over Age 65 (263,400 claims)
$2.5 million in CHAMPUS claims for some 12,000 individual benefits

Enrollment in Blue Shield increased to 1,097,000 persons at the end of 1968, the highest figure recorded. Some 1,270,500 persons are enrolled in Maryland Hospital Service, Inc., programs, Maryland's Blue Cross plan.

BLUE CROSS BOARD

Physician members of the Blue Cross Board are:

J. Tyler Baker, MD, Easton
William D. Lynn, MD, Baltimore
B. Martin Middleton, MD, Baltimore
J. Arthur Weinberg, MD, Baltimore
Richard A. Young, MD, Hagerstown

WORKMEN'S COMPENSATION CHARGES

The Faculty's House of Delegates at its Annual Session voted without dissent to adopt a resolution reaffirming its position with respect to payment of Usual, Customary and Reasonable Fees.

In doing so, the Faculty takes the position that the law provides for payment on this basis; and is willing

WORKMEN'S COMPENSATION CHARGES (cont'd)

to take the issue to court, if necessary.

Insurance carriers repeatedly state they are bound not to exceed the current fee guide promulgated by the Workmen's Compensation Commission in 1961. The Commission Chairman has stated otherwise. However individual Commissioners, when cases have come before them for arbitration, state the guide listing prevails.

The important points in the resolution adopted include

"....there is no reason for medical services rendered to Workmen's Compensation recipients to be compensated for at fees differing from those received for such services rendered to other patients."

and

"....that physicians in Maryland be urged to advise all insurance carriers that they intend to charge Usual Customary and Reasonable fees for...(such) cases seen by them....that physicians who elect not to see such...cases because of this arbitrary attitude...should notify the insurance carriers requesting them to seek the services of other physicians for care of such patients."

TRIP TO SPAIN

The Faculty is planning a jet-charter trip to Spain, October 12 through 21, 1969. Interested persons should contact Mrs. Beverly Wolins, Travel Guide Agency, 416 N. Charles Street, Baltimore, Md. 210 Telephone 727-0682.

1969/70 MEMBERSHIP DIRECTORY

Reply cards with membership listings for the 1969/0 membership directory will be in the mail in the next few weeks. Be on the lookout for them and indicate any changes necessary before returning them to us for printing.

PRESIDENTIAL

Be on the lookout, also, for a communication from the Faculty President.

This four-page letter contains important information regarding the Commission on Medical Discipline as well as other data of current interest and concern.

John Sargeant

Executive Secretary

YOUR NUMBER MAY BE UP

DOCTOR

◆

IT WILL BE FALSE ECONOMY
NOT TO BE ADEQUATELY
PREPARED

◆

YOUR
INCOME TAX RETURNS

MUST

BE SUPPORTED BY
ADEQUATE RECORDS

◆

OUR SERVICE OFFERS YOU

MAXIMUM CONTROL AND SAFETY
FROM BALANCING RECORDS AND
MINIMUM EFFORT ON YOUR PART

◆

FINANCIAL MANAGEMENT
CAN HELP YOU

◆

DIAL 752-5920

Professional Management Co.

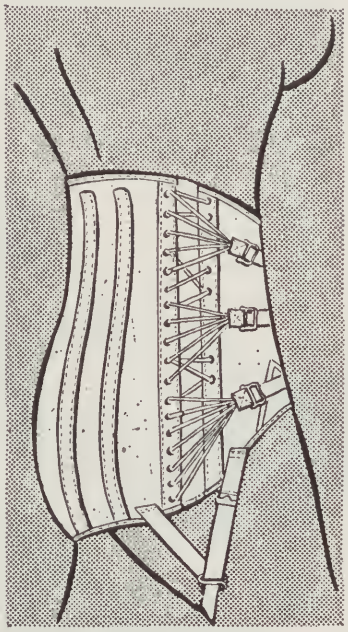
914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN

FEMALE SACRO-LUMBAR SUPPORT

WHITE BROCADE
or DACRON MESH



MODEL 42—Custom type garment tailored for corrective support of the sacral and lumbar areas.

SPECIFICATIONS: White brocade material. Solid back with two 13" removable para spinal steels. Sides laced with three sets of adjusting straps and nylon lacers. Hook and eye opening at left side of front. Size range 24-40. Even sizes only.

SEE OUR COMPLETE LINE OF SURCICAL APPLIANCES

- Cervical Collars
- Arch Supports
- Sacroiliac Belts
- Trusses
- Colostomy and Urinary Appliances



Murray-Baumgartner

SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.
Phone: 669-9300 Baltimore, Md. 21216

Serving the Medical Profession for Almost Half a Century


Darvon®
Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.
900252

ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

MEETING NOTES

The January 14, 1969 meeting of the Board of Directors was called to order by the President, Raymond C. V. Robinson, MD, at 4:30 P.M. Ten members of the Board were present.

The minutes of the December 3, 1968 meeting were approved as written.

Four members of the Society were proposed for Emeritus Membership. These include: Jacob R. Jensen, MD, an associate member of the Baltimore City Medical Society since 1953; Leo Kanner, MD, an active member since 1939; S. Demarco, MD, an active member since 1942; and C. W. Peake, MD, an active member since 1942. All of these physicians have retired from practicing medicine.

Morris B. Levin, MD, appeared before the Board on behalf of two resolutions he had presented at the December 6, 1968 meeting of the Society. These resolutions and two others presented by the Policy and Planning Committee were considered by the Board. The resolutions and the Board recommendations are as follows:

RESOLUTION I-69

PRESENTED BY: The Policy and Planning Committee, Chairman, Philip F. Wagley, MD

RESOLVED, That the Bylaws Committee be directed to draft and present to the Society an amendment to the Bylaws providing that before admission to membership, an applicant attend at least two orientation meetings where he would be informed as to the roles of the Society in the community life and assess what particular interests he might have in those roles.

RECOMMENDATION OF THE BOARD OF DIRECTORS

The Board of Directors agrees wholeheartedly with the intent of this resolution. It was suggested by the Board and agreed to by the Chairman of the Policy and Planning Committee that one orientation meeting would be sufficient to attain the goals set forth in the resolution. The resolution has been amended accordingly and is submitted for adoption as shown below.

If this resolution is passed by the Society, the Board of Directors suggests that an expanded Membership Committee be charged with meeting with the applicants for membership prior to their election to implement this resolution.

AMENDED RESOLUTION I-69

RESOLVED, That the Bylaws Committee be directed to draft and present to the Society an amendment to the Bylaws providing that before admission to membership, an applicant attend at least *one orientation meeting* where he would be informed as to the roles of the Society in the community life and assess what particular interests he might have in those roles.

The Board of Directors recommends adoption of this resolution in the amended form.

RESOLUTION II-69

PRESENTED BY: The Policy and Planning Committee, Chairman, Philip F. Wagley, MD

RESOLVED, That the Society refer to the Policy and Planning Committee the continuing study of socio-economic problems, including the feasibility of setting aside funds for use to defray a significant amount of the cost of pre-medical and medical education for some young student in the inner city.

RECOMMENDATION OF THE BOARD OF DIRECTORS

The Board of Directors recommends adoption of this resolution which charges the Policy and Planning Committee with further study as outlined.

RESOLUTION III-69

PRESENTED BY: Morris B. Levin, MD

WHEREAS, The members of the State Board of Medical Examiners are supposedly voted on by all physicians licensed to practice in the State and in good standing, whether members of societies or not; and

WHEREAS, Each licensed physician throughout the State, in good standing, is entitled to his vote by secret ballot by mail; but, at present many are deprived from doing so; and

WHEREAS, Otherwise, the individual State Society member cannot exercise the inherent right to his direct vote because this right has been usurped by the House of Delegates, which even qualifies submission of resolutions; and

WHEREAS, Our House of Delegates may represent a majority, but not the views of the entire medical profession in the State, be it therefore,

RESOLVED, That the Baltimore City Medical Society direct its delegates to the State Society, to so correct the state and component society bylaws, as to return to each member of the state and component societies, his inherent irrevocable right to vote by secret ballot by mail, for all officers and all matters of importance involving the welfare and existence of the societies, the profession and the public; and, be it further

RESOLVED, That if the Medical and Chirurgical Faculty by its bylaws is unwilling to encompass all physicians in good standing in the State, to vote by secret ballot for members of the State Board of Medical Examiners and other matters of importance to the public; then have the membership petition the legislature to charter a Maryland Physicians' Society, wherein each member shall have the irrevocable inherent right to vote by secret ballot by mail and thereby speak as the voice of the entire State medical profession.

RECOMMENDATION OF THE BOARD OF DIRECTORS

For the reasons listed below, the Board of Directors feels that this resolution should not be adopted.

The Annotated Code of Maryland (Article 43, Section 120) provides that the members of the Board of Medical Examiners be elected by the Medical and Chirurgical Faculty at its Annual Meeting.

The House of Delegates of the Medical and Chirurgical Faculty is composed of members elected by the component societies as their representatives and, therefore, is representative of the membership of the Medical and Chirurgical Faculty.

The Board of Medical Examiners is not elected by the House of Delegates, but by the entire membership of the Medical and Chirurgical Faculty at a general meeting held during the Annual Meeting of the Medical and Chirurgical Faculty.

RESOLUTION IV-69

PRESENTED BY: Morris B. Levin, MD

WHEREAS, Two branches of our State Government are planning comprehensive corrective measures to improve health care to the public; and,

WHEREAS, These branches are trying to halt the ascent of hospital and other health costs; and,

WHEREAS, Hospital administrators claim the greatest rise of hospital costs is due to the public service of their personnel; and,

WHEREAS, These hospitals which can no longer exist without public tax support, restrict the use of their beds and facilities to a small minority of physicians chosen behind closed doors by arbitrary standards; and,

WHEREAS, The denial of the use of hospital beds and facilities by the hospital examining boards to the majority of all physicians in good standing in the community, is a serious discrimination opposed to the public and professional interest and welfare; and, blocks the enhancement of the quality of medical care to the public; and further,

WHEREAS, The finest services to the patient, can be rendered only by his personal doctor; be it therefore,

RESOLVED, That the Baltimore City Medical Society direct its State Society delegates, to petition the legislative and executive branches of our State Government to require uniform examinations and qualifications for all practicing physicians everywhere in the State, whether inside or outside hospitals; and, be it

RESOLVED, That the State Board of Medical Examiners be the sole examining and qualifying Board for this purpose; and if necessary, be so constituted as to certify all specialists and general practicing physicians alike; and, to utilize hospital assistance if necessary for uniformity; and, be it

RESOLVED, That among our profession, privileged individuals or groups be abolished; and, discrimination be based solely on professional qualifications and professional conduct; and, further be it

RESOLVED, That any hospital or other medical institution receiving any tax support and yet discriminating against any person and his physician, by denying the use of its beds and facilities to any doctor on any basis other than such uniform professional qualifications and conduct, shall be denied such tax support or subsidy.

RECOMMENDATION OF THE BOARD OF DIRECTORS

The Board of Directors recommends that this resolution not be adopted.

According to the laws of Maryland, each hospital sets up criteria for election to its professional staff of qualified physicians. The Baltimore City Medical Society and the Medical and Chirurgical Faculty have no control over the individual hospital. In at least two court trials the right of the hospital staff to select its own members has been upheld. One of these decisions declared "The hospital's receipt of public funds and its exemption from taxation did not transfer it into a public hospital, the court said. Since the hospital was a private institution, it had the right to refuse to reappoint the physician to its medical staff." (Quoted from The Citation, Vol. 14, No. 7, p. 107.)

COMMENTS

The Board of Directors has appointed a committee to study several facets of hospital utilization. Some of the problems which will be considered are physicians who want multiple privileges, physicians who want no hospital privileges, physicians who lack proper qualifications for admission to hospital staffs, and the effect of expanded staffs on the accreditation of resident training programs.

The next item under discussion was the selection of a date for the semiannual meeting of the Society. It was agreed that since the first Friday in April is a holiday, the Semiannual Business Meeting will be held on Friday, March 28, 1969.

The annual report of the Liaison Committee between the Hospitals of Baltimore and the Baltimore City Medical Society was discussed. Dr. Robinson suggested and the Board concurred that Samuel Morrison, MD, be asked to remain as chairman of this Committee for the coming year.

The next item on the agenda was the discussion of a letter to be sent to Mayor D'Alesandro regarding the reappointment of Robert E. Farber, MD, as Commissioner of Health for Baltimore city. The Board agreed that Dr. Farber's performance as Commissioner of the Health Department of Baltimore City was one of excellence, and strongly recommended his reappointment.

In response to a request, the Board agreed to give the Med-Chi Subcommittee on Narcotic Prescribing Practices the authority to investigate the prescribing practices of several Baltimore city physicians.

The meeting was adjourned at 6:30 P.M.

The minutes of the February meeting were recorded in the April issue of the JOURNAL.

March Minutes

The Board of Directors of the Baltimore City Medical Society met at 1211 Cathedral Street on March 11, 1969 at 4:30 P.M. The meeting was called to order by Raymond C. V. Robinson, MD.

The minutes of the February 11th meeting were approved.

A lengthly report was submitted from the Health and Welfare Council describing its operation and services. This report was referred to John Classen, MD, for review requesting that a synopsis be prepared and presented to the Board at the next meeting.

The next item on the agenda was the discussion of a letter from Villa Julie College soliciting financial support from the Baltimore City Medical Society. The Board was of the opinion that the hiring of the graduates of this program was in itself supportive and felt that it could not render direct financial assistance to this training program. The Board suggested to the College that perhaps the matter should be considered by the Medical and Chirurgical Faculty.

The Board agreed to waive the dues of Isaac Miller, MD who is unable to practice medicine due to illness.

The next item on the agenda reviewed the purpose of the Baltimore City Medical Society Legislative Committee. It was agreed by the Board that Howard Moses, MD, Legislative Committee Chairman and representative to the State Legislative Committee, should be requested to report to the Board of Directors at any time he feels the Board should be informed of the Committee's activities or when action by the Board is deemed desirable. It was felt, however, that the previous suggestion by the Committee should not be cultivated and the Baltimore City Medical Society should not develop the habit of entertaining local legislators in an attempt to facilitate rapport.

A letter had been received from the Baltimore City Health Department concerning a member of the Society presently under investigation by the Health Department for maintaining a poor facility and housekeeping practices in offices offering medical services. The letter suggested that the Society investigate this matter, however, the Board decided that this specific case was to be turned

over to the Med-Chi Mediation Committee for its consideration and action.

Emmanuel Schimunek, MD informed the Board of the present state of financial investments of the Baltimore City Medical Society. He informed the Board of monies now held by the Society in bank accounts and suggested that some of this be used to purchase stock. After some discussion, it was agreed by the Board that a Society member and recognized financial expert be solicited for his suggestions and advice concerning future investment policies of the Society.

Dr. Robinson read a list of members who have been suspended from the Society for nonpayment of dues. Included in this list are seven active members and twelve associate members of the Baltimore City Medical Society.

The report of the Med-Chi Bylaws Committee as printed in the House of Delegates agenda was discussed. The proposal is to amend the Bylaws to read that the membership on the Med-Chi Council be selected according to the number of active and forty-year members in each district. This would result in the appointment of one representative from each district plus an additional representative for each two hundred active and forty-year members. This recommendation generated much discussion by the Board because the present Bylaw guarantees the Baltimore City Medical Society at least eight Councilors. The proposed amendment eliminates this guarantee so that all of the members from the Central District which includes Baltimore City, Baltimore and Harford counties, could be elected from either Baltimore or Harford county. After some discussion as to the manner in which this amendment could be altered, it was agreed that Dr. Robinson would send a letter to the entire membership informing them of the proposal and asking that they attend the next meeting of the Baltimore City Medical Society to express their views on this important issue. It was suggested that this letter emphasize that the largest segment of the membership in Med-Chi would not be guaranteed representation by the amendment as it now stands.

The next item on the agenda was the billing for laboratory tests. This item again created an enthusiastic response from the Board of Directors. The present policy for the billing of laboratory tests establishes that it is ethical for a physician to charge a fee for drawing blood but he cannot include the cost of the laboratory work in his bill unless the work is done in his office. On the other hand, Blue Shield has established a policy in which it will not pay for charges made by a physician for the drawing of blood and will only pay for the laboratory work performed. It was suggested that the Board of Directors of the Baltimore City Medical Society write the Society of Internal Medicine asking its views on this subject.

Dr. Robinson read several pieces of correspondence he had exchanged with the Med-Chi concerning the activities of the Narcotic Prescribing Practices Subcommittee of the Mediation Committee. Robert B. Goldstein, MD, who is a member of the Mediation Committee, explained that the Committee is now in the process of setting guidelines for the treatment of narcotic addicts to be adopted as policy by Med-Chi. These guidelines will be presented in the near future.

The Board was informed by the Woman's Auxiliary of the Baltimore City Medical Society that its members will serve refreshments at the monthly meetings of the Society.

The Board received a letter from Calbert T. Seebert, MD, Chairman of the Joint Anesthesia Study Committee requesting that funds be set aside by the Society to be used by this Committee to obtain out-of-town speakers. The Board agreed to write to Dr. Seebert expressing its cognizance of the important function served by this Committee and strongly supporting its continued effort. However, the present budgetary status of the Baltimore City Medical Society will not allow the funding as requested. It was suggested that Dr. Seebert contact pharmaceutical companies which market anesthesia supplies and request their financial aid for such a program.

Edward F. Cotter, MD, who is Chairman of the Committee to Study Hospital Privileges reported that this Committee had formulated a questionnaire which will be mailed to the membership asking information concerning their hospital privileges. Several suggestions were made concerning the wording and information to be gleaned from such a questionnaire by the Board of Directors. The questionnaire was then returned for further refinement prior to its next presentation to the Board.

A suggested amendment to the Baltimore City Medical Society Bylaws proposing that the slate of nominations be sent to the membership fifteen days before the presentation at the November meeting was discussed. Presently, the Bylaws require that the slate be sent out thirty days prior to the meeting which necessitates including the

slate in the mailing of the October bulletin. The Board agreed to request to the Bylaws Committee to prepare an appropriate amendment to the Bylaws.

The meeting was adjourned at 6:15 P.M.

Baltimore County Medical Association

Wilmer K. Gallagher, Jr., MD, president of the staff at St. Agnes Hospital, extended a cordial invitation to the members of the Baltimore County Medical Association to hold the March meeting at the Hospital. Following a delicious buffet luncheon, a very interesting scientific program was presented. The subject was "Medical Versus Surgical Concepts in the Treatment of Hyperthyroidism." The speakers were Luis Martin, MD, endocrinologist at the University of Maryland, and James Cianos, MD, a surgeon on the staff at St. Agnes. This is certainly a very controversial subject and was well received by our members. Our sincere thanks to the participants.

The following were elected to active membership: Joseph Cordi, MD, Theodore Toulan, MD, and Robert Yim, MD. The following physicians, all residents at the Sheppard and Enoch Pratt Hospital, were elected to associate membership: Cynthia Dulay, MD, Robert Duvall, MD, Ronald Goldberg, MD, Seana Herchfeld, MD, Kay Koller, MD, Harold Levin, MD, Apoltolos Pappas, MD, Betty Robinson, MD, Gerardo Rubenstein, MD, and Luciana Santiago, MD.

Our April meeting will be held at the Sheppard and Enoch Pratt Hospital and also in April our Association is holding a Dinner-Dance at the Tail of the Fox in Timonium.

Our Annual Crab Feast will be in August.

Do Your Patients Need Nursing Service?

Call **889-5666**

COBB-WOODS SERVICES

Vera Woods, M. A. Director

2213 St. Paul St. Baltimore, Md. 21218

Licensed by the State of Md.



THE BETTMANN ARCHIVE

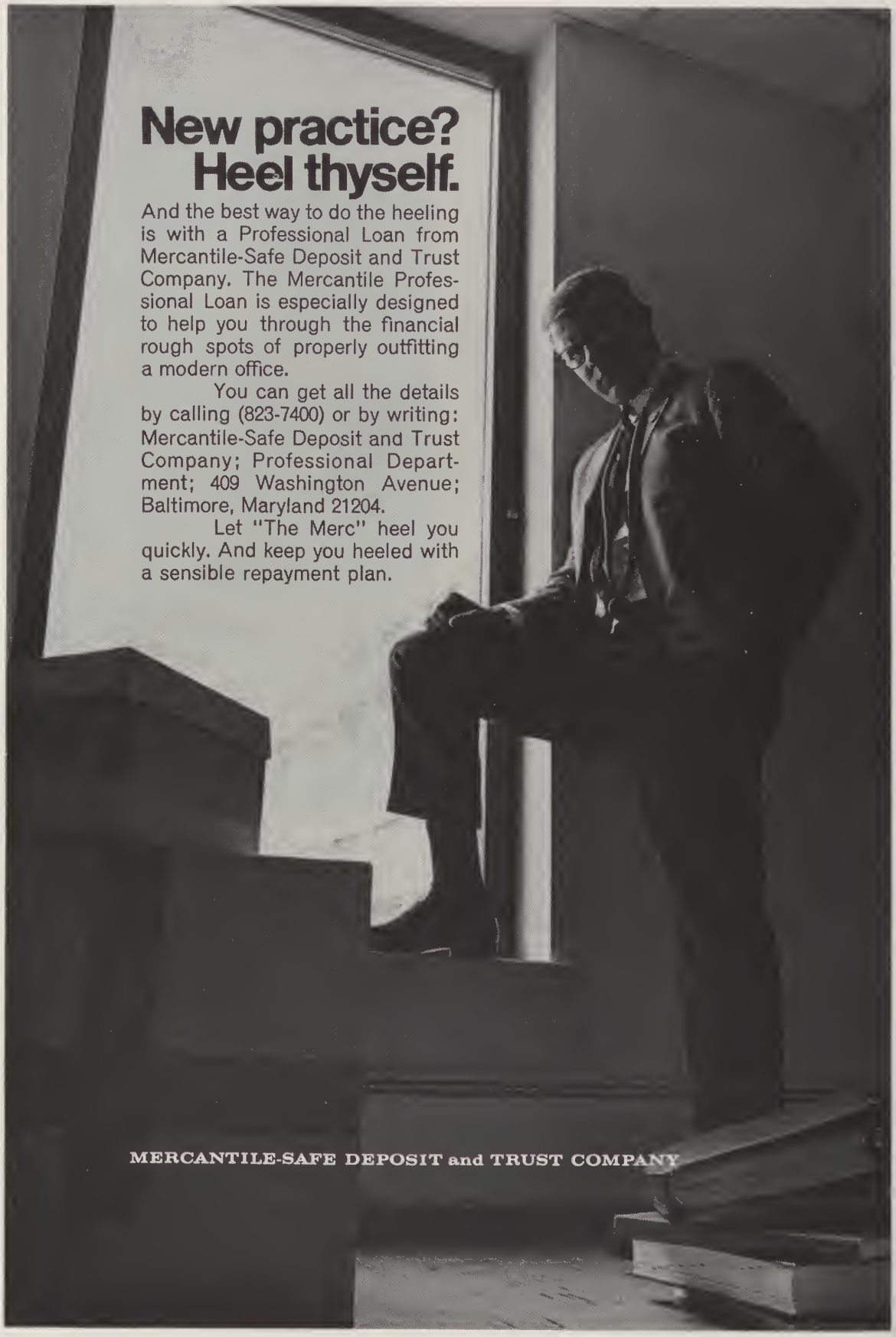
Just one tablet at bedtime • Prevents painful night leg cramps • Permits restful sleep

How many of your patients stamp their feet at night and lose sleep because of painful leg cramps? Unless prompted, they usually fail to report this distressing condition and suffer needlessly.

One tablet of QUINAMM at bedtime usually controls distressing night cramps and permits restful sleep with the initial dose.

Prescribing information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Side Effects/Precautions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144


New practice?
Heel thyself.
And the best way to do the heeling is with a Professional Loan from Mercantile-Safe Deposit and Trust Company. The Mercantile Professional Loan is especially designed to help you through the financial rough spots of properly outfitting a modern office.
You can get all the details by calling (823-7400) or by writing: Mercantile-Safe Deposit and Trust Company; Professional Department; 409 Washington Avenue; Baltimore, Maryland 21204.
Let "The Merc" heel you quickly. And keep you heeled with a sensible repayment plan.
MERCANTILE-SAFE DEPOSIT and TRUST COMPANY

THE MONTH IN WASHINGTON

The Department of Health, Education and Welfare has issued proposed regulations setting standards for rubella vaccine, making it possible for it to be ready for distribution in limited quantities by about June 1.

The standards cover production methods, safety, purity, and potency. They were developed by the Division of Biologics Standards, a unit of the National Institutes of Health. Final regulations could be published as early as May 3. Indications were that two manufacturers would have a vaccine ready for initial distribution soon after the regulations had been made final.

"This means that we are one step closer to the prevention of a disease that has caused an untold number of tragic births," HEW Secretary Robert H. Finch stated when the proposed regulations were issued.

"We are moving ahead to combat German measles in the quickest manner consistent with public safety."

The regulations apply to vaccines containing a live virus strain known as HPV-77, which is grown in either duck embryo or dog kidney cell culture systems. Experimental vaccines produced in accordance with the standards have undergone extensive community testing in the United States and abroad. Two manufacturers, Merck, Sharpe & Dohme and Philips Roxane Laboratories, have produced vaccines based on this strain.

"We hope that more than one vaccine will be available," Robert Q. Marston, MD, NIH Director, said. "Regulations covering the use of other virus strains and culture media for rubella vaccine production will be formulated on the basis of extensive tests now going on."

Smith Kline & French Laboratories has tested widely an experimental vaccine containing the Cendehill strain of rubella virus.

An HEW announcement stated:

"German measles is a threat to susceptible pregnant women any time, but the threat increases significantly during epidemic years. One of the most tragic and disastrous epidemics to hit the United States in modern times was the German measles epidemic of 1964-1965. This resulted in about 50,000 abnormal pregnancies. About 20,000 infants were born with such crippling defects as mental retardation, heart disease, blindness and deafness. The remaining 30,000 pregnancies terminated in miscarriage or stillbirth.

* * *

The Food and Drug Administration has taken the first step to halt the marketing of 78 antibiotic combination products.

The ultimate action was recommended by the National Academy of Sciences-National Research Council, which is evaluating the effectiveness of about 3,600 new drugs marketed from 1938 to 1962.

Generally, the 78 products were found ineffective as fixed combinations for claims made in their labeling. The FDA emphasized that this does not necessarily mean that either the antibiotics or other active ingredients of the products are ineffective when used alone.

"But the use of two or more active ingredients in the treatment of a patient who can be cured by one is irrational therapy," said Herbert L. Ley, Jr., MD, Commissioner of Food and Drugs. "It exposes the patient to an unnecessary risk. Antibiotics should be used like a rifle rather than a shotgun."

The majority of the 78 products are antibiotic-sulfa combinations in tablet, capsule, or liquid form. Also included are 16 penicillin-streptomycin combinations that are given by injection.

Other antibiotics used in the preparations include erythromycin, neomycin, tetracycline, chlortetracycline, nystatin, oxytetracycline, oleoandomycin, and triacetyloleandomycin. In addition, some of the preparations contain analgesics, vitamins, or other ingredients.

The antibiotics combinations are the products of 21 different manufacturers, including Chas. Pfizer & Co.; Eli Lilly & Co.; Lederle Laboratories, division of American Cyanamid Co.; Bristol Laboratories, Inc., a division of Bristol-Myers Co.; Merck & Co.; E. R. Squibb &

Sons Inc., a subsidiary of Squibb Beech-Nut Inc.; Upjohn Co.; Wyeth Laboratories Inc., a subsidiary of American Home Products Corp.; Abbott Laboratories; and Hoffman-La Roche Inc. In an earlier proposal last December, the FDA similarly moved against products marketed by Squibb, Lederle and Upjohn.

Many of the affected products have been promoted widely and have found wide acceptance in the medical profession. Several of the manufacturers promptly said they would contest the FDA ruling and others were expected to oppose it also. The manufacturers were given 30 days to submit any new data on efficacy of the products.

There were 12 products in the first groups, announced last December. A decision still was pending on whether manufacturers of those products should have additional time to submit evidence of efficacy.

The FDA can halt the marketing of antibiotic-containing preparations by deleting them from regulations listing the antibiotic drugs acceptable for certification. Antibiotics and insulin, unlike other drugs, must be certified on a batch-by-batch basis before they can be marketed.

* * *

Two spokesmen for the medical profession asserted before a Senate subcommittee that the policies and scientific journals of their organizations are not biased in favor of the prescription drug industry because of the drug advertising revenue.

Sen. Gaylord Nelson (D., Wis.), chairman of the Senate Monopoly Subcommittee which is making a broad study of the ethical drug industry, accused the medical journals of following the pharmaceutical industry's line to get advertising dollars.

Both Edward R. Annis, MD, a member of the AMA Board of Trustees, and Maynard I. Shapiro, MD, president of the AAGP, emphatically denied the charge. Both cited the high, objective advertising standards of their organizations' publications.

"The American Medical Association's programs and policies have never been, are not now, and will never be shaped by any dependence on the drug industry," Dr. Annis said. "And to assure that there is no conflict of interest, the AMA has consistently separated the editorial management, advertising acceptance, and business management of each of its scientific publications. . . .

"We believe that no publication surpasses our own standards for acceptable advertising."

Nelson sharply criticized the *Journal of the American Medical Association* as to the ads it carried on chloromycetin after the drug had been judged to be extremely dangerous. Annis acknowledged that "one Madison Avenue effort . . . slipped through the net" of AMA advertising standards. But he pointed out the various warnings on the drug which were carried in the editorial section of *JAMA* and other AMA publications.

"Advertising is screened by a group of physicians, all of whom we consider qualified to perform their task," Dr. Shapiro explained. "We don't list the names of these physicians in our magazines because we believe they prefer a degree of anonymity. All are medical school faculty members and all, in our opinion, are well qualified to screen pharmaceutical advertising."

Dr. Shapiro also said that at least two drugs firms had canceled ads in AAGP publications after they had carried editorials adverse to the companies.

* * *

The Nixon Administration recommended to Congress that the Hill-Burton hospital construction and improvement program be changed to permit block allocation of grant funds to states.

Since enactment of the first Hill-Burton legislation in 1946, federal grants for it have been earmarked for specific purposes.

In a statement to the House Health Subcommittee, Robert H. Finch, secretary of Health, Education and Welfare, said the nation's health needs had changed since the Hill-Burton program was started.

Today's needs, he said, are two-fold:

● Modernization or replacement of existing and obsolete acute care facilities in the hospitals and ● Expansion of other kinds of medical facilities to reduce the pressures on hospitals and help curb skyrocketing medical costs.

He recommended a $150 million annual grant authorization for construction, replacement or modernization of the most critical types of health facilities.

"Additionally, we recommend the removal of the existing Hill-Burton categories to

provide a better balance of health care facilities in the community by assisting those kinds of facilities which traditionally have been neglected or in short supply," he said.

Expansion of neighborhood health center programs also was recommended. The HEW statement said it was required to meet the health needs of the poor.

H. Phillip Hampton, MD, Tampa, Fla., testifying for the AMA, said the AMA continues its long-standing support of the Hill-Burton program but believes that "the major need that exists today is for the improvement and effective use of existing facilities."

"Priority for modernization and the upgrading of existing facilities will lessen the strain on the available supply of health personnel needed to provide services obtained in hospitals and related facilities," he said.

The AMA supported a provision in one of the two Hill-Burton bills before the subcommittee that would permit states to transfer funds from one allocation to another, providing "further elasticity to the transfer of funds from construction to modernization."

The AMA opposed, as unnecessary, the establishment of Hill-Burton priorities for construction or modernization of outpatient facilities or facilities to provide comprehensive health care. Such needs should be met through other laws already enacted, the AMA said. Dr. Hampton explained:

"We hope to make this point clear: We understand the part played by hospital outpatient departments in providing a place for necessary services to a community, and to the role played in teaching and training. But we believe that any need for outpatient facilities, separate and apart from the hospital, or for free-standing diagnostic and treatment centers—or whatever they may be called—can be met through other programs which provide Federal assistance. The Hill-Burton program is not the appropriate vehicle for grants or priorities for such separated facilities. Nothing has been demonstrated which indicates either public benefit or public acceptance for this concept of providing ambulatory medical care through hospital operated, rather than physician operated, neighborhood clinics."

DOCTORS' OFFICES

LARGE

MEDIUM

SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

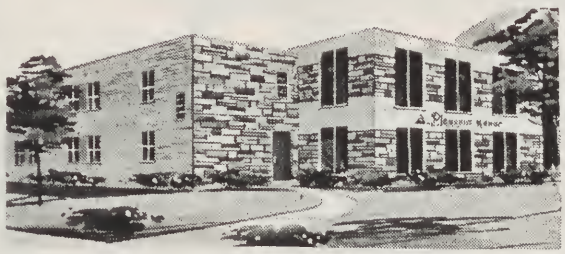
ELEVEN E. CHASE ST.

CORPORATION

11 E. Chase St.

Phone 539-8553

"The Best of Care for Those You Love"



Pleasant Manor

CONVALESCENT AND NURSING CENTER

ONE OF THE NEWEST, MOST MODERN PARA-MEDICAL FACILITIES

Round-the-clock care by Professional Staff
Complete Intensive Care Units
Physical and Occupational Therapy

Excellent Meals--Kosher Food on Request
Air-Conditioned, Fire-resistant Building
Centrally Located Near Sinai Hospital
Your Inspection Invited

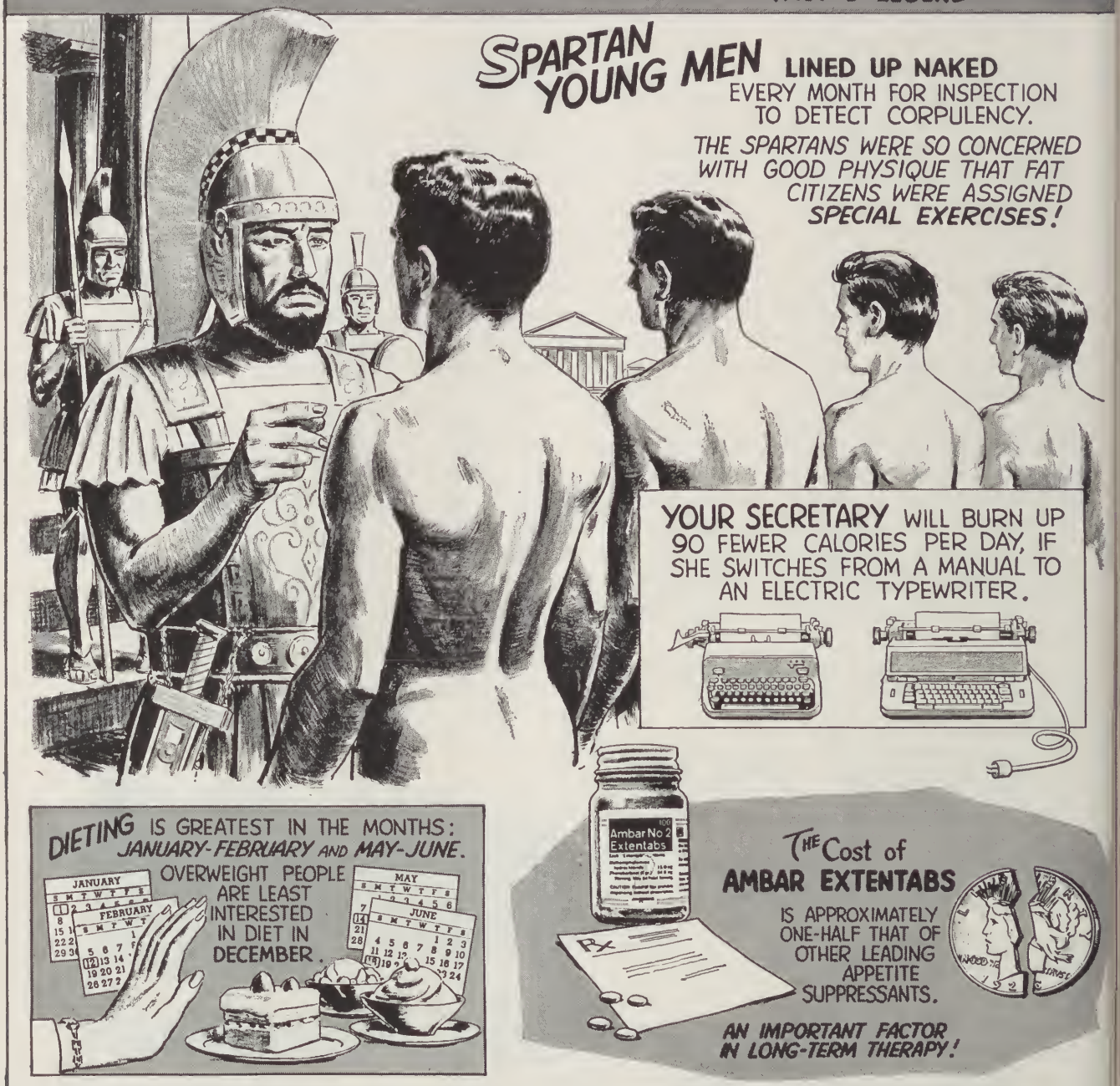
4615 PARK HEIGHTS AVE.
BALTIMORE, MD.

542-4800

The AMBAR SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOS

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Amb suppresses appetite and helps offset em tional reactions to dieting. **Contraindic tions:** Hypersensitivity to barbiturates sympathomimetics; patients with advanc renal or hepatic disease. **Precautions:** Administer with ca tion in the presence of cardiovascular disease or hypertensio **Side Effects:** Nervousness or excitement occasionally not but usually infrequent at recommended dosages. Slight dro iness has been reported rarely. See package insert for furth details.

A. H. ROBINS COMPANY,
RICHMOND, VA. 23220

A·H·ROBIN

Thursday, Friday, Saturday, September 4, 5, 6,

1969 Semiannual Meeting of the Medical and Chirurgical Faculty of Maryland

A meeting of interest and fun for all physicians, their wives, and families is being planned. In addition to the business and scientific sessions there will be several social events, a tour of the Amish Country for the ladies, and a tour of the new Hershey Medical Center of the Pennsylvania State University for the physicians.

More about the program will be published in the June issue of the Journal and the complete program will be mailed to all members of the Faculty early in August.

Complete and mail the following reservation form NOW.

SEE YOU IN HERSHEY!

DeWitt E. DeLawter, MD, Chairman
Committee on Program and Arrangements

Medical and Chirurgical Faculty of Maryland

HOTEL HERSHEY

September 4, 5, 6, 1969

PLEASE CHECK THE APPROPRIATE SPACES AND RETURN PROMPTLY TO:

Mr. Harvey S. Schell, Reservations Manager
Hotel Hershey, Hershey, Pennsylvania 17033

ROOM RATES: AMERICAN PLAN, WITH MEALS

Twin-bedded rooms . . . . . $24.00 per person per day—2 in a room

Single rooms . . . . . $27.00 per person per day

(A 15% Gratuity to be added to the above rates. This takes care of the Dining Room Personnel on food only, bellmen for check in and out, maids and doormen. Individuals to do other tipping on their own, such as room service, beverage bills, etc.)

PLEASE RESERVE THE FOLLOWING ACCOMMODATIONS:

. . . . . Twin bedded rooms

. . . . . Single rooms

. . . . . .
NAME OF MEMBER SHARING ROOM

ARRIVAL DATE . . . . . DEPARTURE DATE . . . . . .
(ROOMS NOT AVAILABLE UNTIL 4:00 P.M.) (1:00 P.M. CHECK OUT TIME)

. . . . . .
DATE

MEDICAL AND CHIRURGICAL FACULTY

OF THE STATE OF MARYLAND

MED-CHI

Members Retirement Plan

TRUSTEE AND ADMINISTRATOR

Mercantile-Safe Deposit and Trust Company

INVESTMENT ADVISOR

T. Rowe Price and Associates, Inc.

LIFE UNDERWRITER

Shenandoah Life Insurance Company

FOR MORE INFORMATION DETACH AND MAIL SLIP DIRECTLY TO:

MED-CHI MEMBERS
RETIREMENT PLAN
1211 Cathedral Street
Baltimore, Maryland 21201

Name .....

Address .....

City ..... State ..... Zip Code .....

Telephone Number ..... Date of Birth .....
(month) (day) (year)

Letters to the Editor

Dear Editor:

A commentary is necessary on the Ethics Corner Comment (January issue) with regard to the use of credit cards. Many physicians have been confused about the availability of the use of these credit cards, and your explanation is very timely.

However, attention must be directed to the fact that the entire economy of these United States is now based on credit. The fact that many of us were reared on a pay-as-you-go plan, does not gainsay the fact of present day existence which is nearly a total credit economy. In some respects we do ourselves a great disservice in not recognizing the changing times and making changes that are sensible and in the public interest, prior to the time that they are rammed down our throats.

Cases in point, of course, are the Medicare-Medicaid programs, which are with us and will be progressively managed by either ourselves or the federal and state governments. A similar situation exists with the use of credit and our failure to become modern enough to realistically cope with a situation which is upon us and will not change. The average person budgets practically their entire life against a credit system and completely runs afoul of his thinking when faced with medical bills. One fails to understand the reticence which is evident in this failure to use the credit card system. In fact, an agonizing reappraisal with some younger minds appears much in order immediately to make a determination of whether or not we are hastening our own downfall by failure to face the facts and endorse a socio-economic fait accompli.

For one, I believe that we should endorse, activate and supervise credit card systems related to our medical practice and take ourselves to the greatest extent possible out of the bill collecting and finance business.

Sincerely,

ROSS Z. PIERPONT, MD
Baltimore

Dear Editor:

For two years I have been concerned about regulations as published in the "Laws, Rules and Regulations" distributed by the Medical and Chirurgical Faculty of the State of Maryland.

In the December 1966 issue it is stated (regarding laboratory services) that "all billing should be done by the laboratory doing the service. If a clinician and a laboratory share the responsibility of the laboratory procedure, each should send a bill for services rendered." It further states that "it shall be considered unethical for any physician to bill for laboratory services not performed by him or his regularly supervised employed assistants." It is also considered unethical to "collect fees from any insurance company for laboratory services not performed by him or his regularly employed assistants."

Since I consider the word unethical to denote basic dishonesty, I cannot help but resent these regulations. To my knowledge, the medical society has not voiced an active opinion regarding this and I think it is time that they do. Of recent date there has been some question through the insurance carriers regarding this very problem. It would seem that those ethical physicians, who provide the laboratory materials and perform the services required in obtaining specimens and interpreting them, are being unjustly judged. In many instances, laboratory services are done at a much lower cost to a patient than at a hospital laboratory or privately owned local laboratory, and the results have proved consistently accurate. I cannot conceive how it is unethical to pass savings on to patients and provide a greater medical profile and service to them. Also, I have no knowledge of any insurance carrier who is willing to split the cost of laboratory procedures and pay both the laboratory performing the actual determination and the physician who shares the responsibility of obtaining the procedures and associated involved expense. Since the federal government has seen fit to authorize payment to physicians for laboratory services performed in an approved laboratory, it would seem that our local society and the state society should consider discarding what appears to be a bit of "in-fighting" and allow the physician the discretion and respect to which he is entitled. *(From the Montgomery County* Bulletin.)

Respectfully,

MORRILL C. QUINNAM, JR., MD
Silver Spring

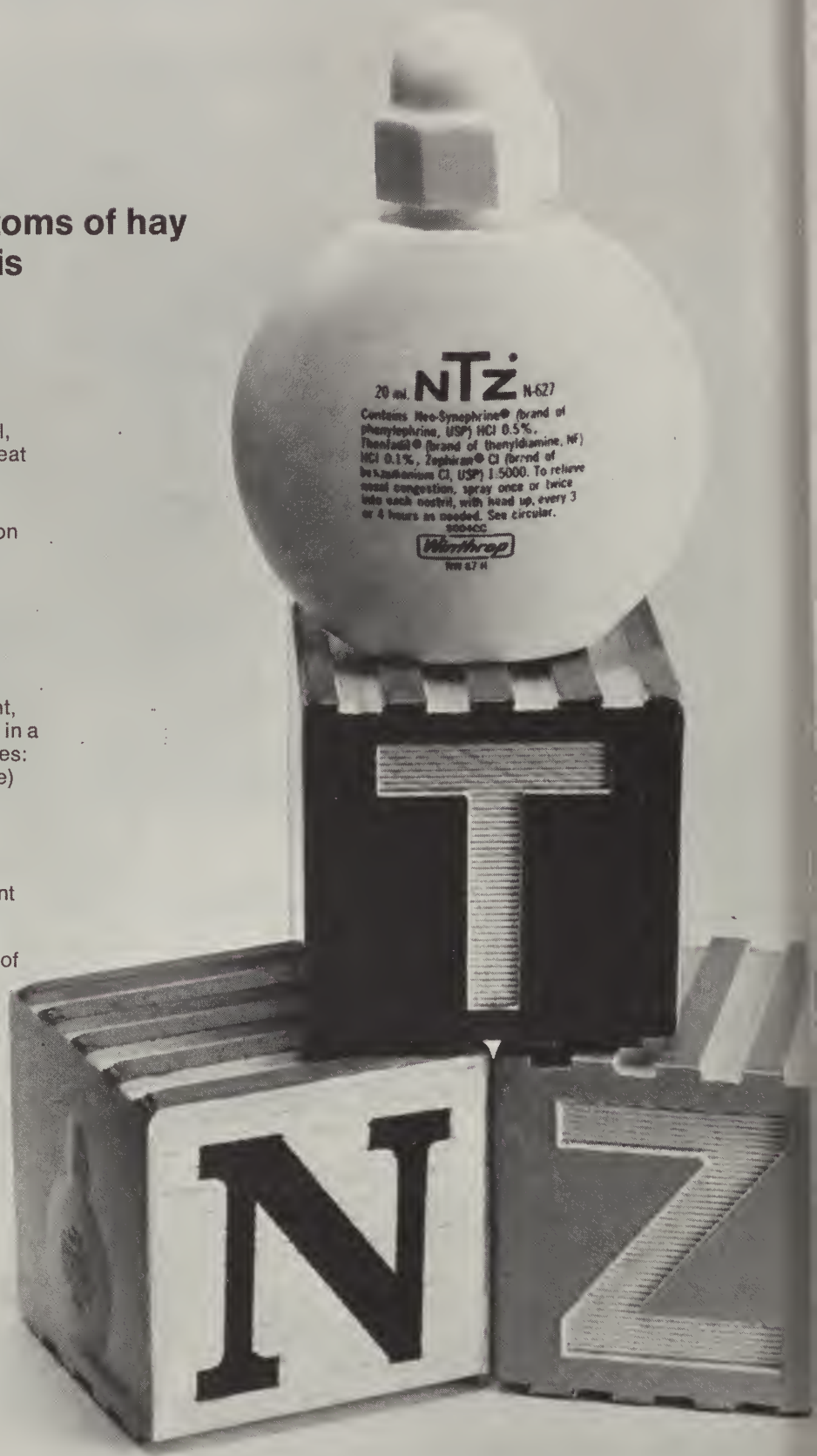
as easy as NTZ®

An easy solution to the problem of nasal symptoms of hay fever, colds and sinusitis

- easy to prescribe: just write NTZ Nasal Spray.
- easy to recommend: just say NTZ Nasal Spray.
- easy to use: just one spray in each nostril, quickly followed by a second spray. Repeat q. 3 h. or q. 4 h. for temporary relief.
- easy to dispense: the outer sleeve of the package is removable for easy application of prescription label.
- easy to remember: as easy as NTZ.

But more than a simple vasoconstrictor:
NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine®, 0.5 per cent, the more potent solution (adult strength) in a carefully balanced formula which includes:
Neo-Synephrine (brand of phenylephrine) HCl 0.5 per cent, decongestant
Thenfadil® (brand of thenyldiamine) HCl 0.1 per cent, antihistamine
Zephiran® (brand of benzalkonium, as chloride, refined) Cl 1:5000, wetting agent

Available: NTZ Nasal Spray in squeeze bottles of 20 ml.; NTZ Solution in bottles of 1 oz. with dropper.



prescribe NTZ® Nasal Spray
(contains Neo-Synephrine)

Winthrop Laboratories, New York, N. Y. 10016 Winthrop



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Hewson on the Blood

The treasures of our library continue to be unearthed, so to speak, at each monthly visit of our Library Consultant. In January we discovered the very rare *Experimental Inquiries* of William Hewson, 1739-74. All three volumes, delineating the author's important researches, fundamental to human physiology, were found in the Library stacks. Hewson, in his first volume of 1772, established the fact that fibrinogen caused blood coagulation; the 1774 (first edition) work "gave the first complete account of the anatomical peculiarities of the lymphatics and described the origin of leucocytes"; the third book (1777) published posthumously, described in its first edition Hewson's additional observations and experiments. Very few medical libraries can boast of complete sets of this very important series of medical classics by one of the Hunters' outstanding students. But in addition, in March, in another part of the Library, Mr. Ash also uncovered (through his book by book inspection of the shelves) the first edition (1771) of the first part of the set, of which the previously found 1772 edition was the first revision. Thus the Med-Chi Library is the proud possessor of a complete set of this outstanding and most important rarity in the fields of blood research and experimental medicine.

Here is another example of the usefulness of our consultant's work. None of these books was entered in the incomplete public catalog of the Library, although we did have a shelf list (inventory) of them, but no record by author or subject. Thus librarians, readers, or reseachers have had absolutely no way of knowing about their existence. Fortunately, the catalog program of the past few years is under efficient professional control and only the older cataloging is in dire need of complete revision in order that we can discover and use the Library's remarkable resources which, Mr. Ash says, make up one of the nation's finest historical and rare medical book collections.

Meetings Here And There

By the time this issue appears the Med-Chi annual meeting will be history and your librarian will have attended the Third International Congress on Medical Librarianship held in Amsterdam May 5-9. The last International Congress was held in Washington in 1963 and convened a colorful collection of librarians from all over the world.

* * *

At the March meeting of the Baltimore Hospital Librarians Association the members voted to plan another meeting of hospital and medical librarians for the annual Tri-State Hospital Association meeting in Washington, December 1-3, 1969.

* * *

NEW ACCESSIONS—BOOKS

(Arranged by author and title)

Adriani, John
Appraisal of current concepts in anesthesiology. St. Louis, Mosby. 1968.

The Arthritis Foundation
Gout: a handbook for patients. New York, Arthritis Foundation. 1966.

The Arthritis Foundation
Osteoarthritis: a handbook for patients. New York, Arthritis Foundation. 1967.

The Arthritis Foundation
Rheumatoid Arthritis: a handbook for patients. New York, The Arthritis Foundation. 1966.

The Arthritis Foundation
Today's fact about arthritis. New York, The Arthritis Foundation. 1966.

Artz, Curtis Price
The treatment of burns. 2d. ed. Philadelphia, Saunders, 1969.

Association of American Physicians.
Transactions of the Association of American physicians. V. 81 Philadelphia, Association of American Physicians. 1968.

Biggs, Ernest R., Jr.
Conditioning for football. Dubuque, Iowa, W. C. Brown Co. 1968.

Collected works on cardio-pulmonary disease, by the Heineman Foundation Laboratories, Charlotte, N. C., Charlotte Memorial Hospital, 1968.

Cope, Oliver
Man, mind & medicine, the doctor's education; a chairman's view of the Swampscott Study on Behavioral Science in Medicine, 23 October-4 November 1966. Philadelphia, Lippincott. 1968.

Davis, Hallowell
Hearing and deafness; a guide for laymen. New York, Murray Hill Books, 1947.

Dolének, Antonin
Color atlas of diabetic retinopathy. Chicago, Year Book Medical Publishers, 1967.

Duke-Elder, Sir William Stewart
System of ophthalmology. Volume 10, Diseases of the retina. St. Louis, Mosby 1967.

Edwards, Henri Milne
Outlines of anatomy and physiology. Boston, Charles C. Little and James Brown, 1841.

Freud, Sigmund
Infantile cerebral paralysis. Coral Gables, Fla., University of Miami Press, 1968.

Goldman, Douglas
Practical psychiatry for the internist. St. Louis, C. V. Mosby Co., 1968.

Hartstein, Jack
Questions and answers on contact lens practice. St. Louis, Mosby, 1968.

Helfer, Ray E.
The battered child. Chicago, University of Chicago Press, 1968.

International Congress on Nutrition, 5th, Washington, D.C., Sept. 1-7, 1960.
Abstracts. Washington, n.d.

The Johns Hopkins Medical Institutions.
Information sources in hearing, speech and communication disorders. Part 1. Baltimore, The Johns Hopkins Medical Institutions, 1968.

Kielholz, Paul
Diagnosis and therapy of the depressive states. Basle, J. R. Geigy, 1959.

Knowles, John H.
Hospitals, doctors, and the public interest. Cambridge, Harvard University Press, 1965.

Lopate, Carol
Women in medicine. Baltimore, published for the Josiah Macy, Jr. Foundation by the Johns Hopkins Press, 1968.

Meares, Ainslie
Relief without drugs. 1st edition. Garden City, N. Y., Doubleday, 1967.

Medical Examination Review Book
Internal medicine specialty board review. 2nd. ed. Flushing, N. Y., Medical Examination Publishing Co., 1968.

Miles, Stanley
Underwater medicine. 2d. ed. Philadelphia, Lippincott, 1966.

National Association of Blue Shield Plans.
Annual Report, 1967/68. Chicago.

Nephrology, by Jean Hamburger et al. Philadelphia, W. B. Saunders Co., 1968.

O'Neal, Lawrence W.
Surgery of the adrenal glands. St. Louis, C. V. Mosby Co., 1968.

Pfeiffer, Eric
Disordered behavior. New York, Oxford University Press, 1968.

Polatin, Phillip
A guide to treatment in psychiatry. Philadelphia, Lippincott, 1966.

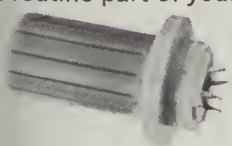
Presbyterian—St. Luke's Hospital. Chicago.
Research report, 1967-1968. Chicago, Presbyterian—St. Lukes Hospital, 1968.

Rendle-Short, John
A synopsis of children's diseases. 4th ed. Baltimore, Williams & Wilkins, 1967.

Sex Information and Education Council of the U.S.
Sexuality and the life cycle. Siecus Publications, 1969.
Sherlock, Sheila
Diseases of the liver and biliary system. 4th ed. Philadelphia, F. A. Davis, 1968.
Steinhart, Sydnae
Rare medical books: format and processing. Baltimore, Welch Medical Library, 1968.
Szurek, Stanislaus Andrew
Training in therapeutic work with children. Palo Alto, California, Science and Behavior Books, 1967.
Tax Foundation, Inc.
Medicaid: state programs after two years. New York, Tax Foundation, Inc., 1968.
U.S. National Institute of Mental Health.
Support programs. Washington, U.S. National Institute of Mental Health, 1967.
U.S. National Institutes of Health.
A special report on emphysema. U.S. Public Health Service, 1968.
U.S. Public Health Service. Division of Medical Care Administration.
Utilization review. A selected bibliography, 1933-67. Washington, U.S. Public Health Service, 1968.
U.S. Social Security Administration.
Questions and answers on health insurance for the aged. Washington, 1965.
U.S. Social Security Administration. Library.
Medicare: a bibliography of selected references 1966/1967. Baltimore, U.S. Department of Health, Education, and Welfare, 1968.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.

SUBTLE SEDATION

Solfoton®

Sedation without peaks and valleys

REMOVES THE MENTAL BLUR
THAT CLOUDS VISION

CONSTRUCTIVE THERAPY—Solfoton in any form taken at 6 hour intervals maintains sedation at the threshold of calmness, sustaining a mental climate for purposeful living.

Each tablet or capsule contains:

PHENOBARBITAL (Warning: may be habit forming) ...16 mg.
BENSULFOID® (See P.D.R.) ..... 65 mg.

Precaution: same as 16 mg. phenobarbital

Literature and clinical supply available to physicians.

FEDERAL LAW PROHIBITS DISPENSING WITHOUT PRESCRIPTION

AVAILABLE

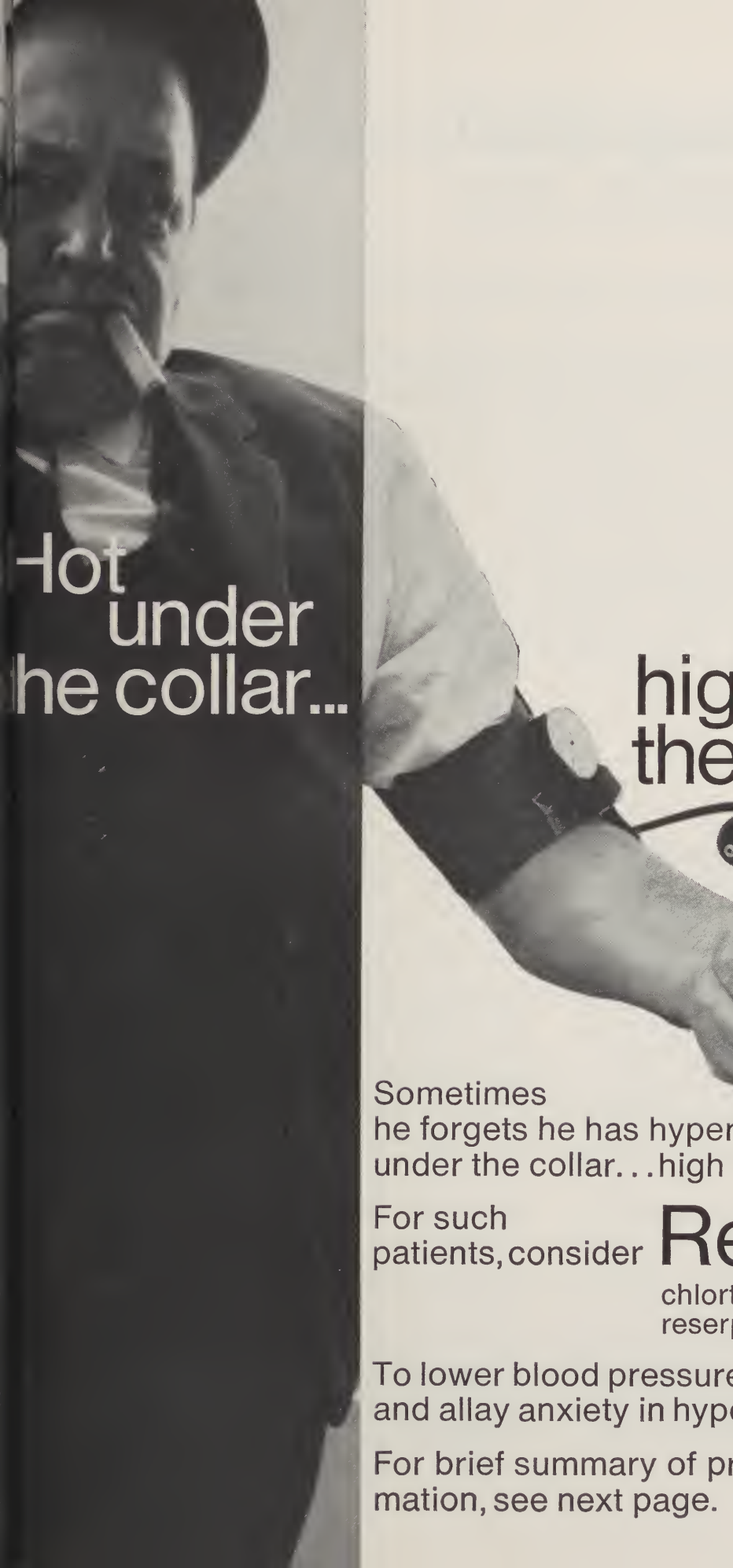
SOLFOTON ..... (yellow, uncoated tablets "P")
100s, 500s, 5000s
SOLFOTON CAPSULES ..... (yellow and brown)
100s, 500s, 1000s
SOLFOTON S/C ..... (sugar-coated, beige tablets)
100s, 500s, 4000s

WILLIAM P. POYTHRESS & CO., INC.
RICHMOND, VIRGINIA 23217
Manufacturers of ethical pharmaceuticals since 1856

Solfoton®

SUBTLE SEDATION





Hot under he collar...

high under the cuff.

Sometimes
he forgets he has hypertension, gets hot under the collar...high under the cuff.

For such patients, consider **Regroton®**

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

To lower blood pressure and allay anxiety in hypertension.

For brief summary of prescribing information, see next page.

RE-6392

Regroton®

Geigy

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

the once-a-day tablet for anxious hypertensives

Regroton is a combination of two basic antihypertensives designed to lower blood pressure and allay anxiety in hypertension. With Regroton he can keep his shirt on and you can keep his blood pressure down.

Before prescribing, please review carefully the indications, contraindications, warning, precautions, adverse reactions and dosage information below.

Regroton®
Each tablet contains:
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Indications: Hypertension.
Contraindications: History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases.
Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs.
Use in pregnancy: Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increased respiratory secretions, nasal congestion, cyanosis and anorexia may occur in infants born to reserpine-treated mothers.
Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs, or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. To avoid hypotension during surgery, discontinue therapy with this agent two weeks prior to elective surgical procedures. In emergency surgery, use, if needed, anticholinergic or adrenergic drugs or other supportive measures as indicated. Because of the possibility of progression of renal damage, periodic kidney function tests are indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated. Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.
Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients.
Adverse Reactions: The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis). drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible.
Average Dosage: One tablet daily with breakfast.
Availability: Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C
For details, please see complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

RE-6392

The Serologic Syphilis Test Required for Marriage in Other States

Robert L. Cavenaugh, MD
Director, Bureau of Laboratories
Maryland State Department of Health

Persons in other states who wish to get married in Maryland are indeed fortunate, judging by the amount of trouble and red tape Marylanders must go through if they want to get married in any of the 45 states that require a premarital test for syphilis. Each of these states has its individual, specific regulations and its own forms for certifying to the premarital test. All are different, some calling for a physical examination, some accepting merely the laboratory test, and among them is a wide variety of the types of tests and of laboratories that are acceptable. Moreover, it it obviously impossible for each of these states to provide its certification forms to all the county clerks of every state whose citizens might want to be married within the boundaries of that particular state.

One important uniformity exists: All 45 of these premarital-law states will accept tests performed by the central public health laboratory of any other state. Because of this, furthermore, the Maryland Health Department's Central Laboratory maintains a supply of the proper forms and certificates for all states—and for New York city, District of Columbia, and some provinces of Canada—that require the premarital syphilis test.

The purpose of this article is to inform those concerned, and to ask them to inform their staff representatives, as to the easy and effective method for obtaining the premarital serologic test for syphilis (STS) for marriage in any state (except those listed below which have no such requirements).

States Having No Requirement of Premarital Syphilis Testing

Maryland
Minnesota
Nevada
South Carolina
Washington

The prospective partners in Maryland can go to any health office or to any physician's office, hospital or laboratory. There the blood is drawn into the STS tube, which is a component of the "STS Outfit" available from the Bureau of Laboratories (Central or Branch Laboratories). This "outfit" contains the request form, MB-1-1-Ce, on which the identifying information is to be entered. Essential, of course, is an Additional Entry identifying that it is for a premarital test and naming the state and city in which the marriage is to be performed.

If the physician's office does not have on hand the "STS Outfit" but can provide a clean, stoppered test tube for collecting 5 to 8 milliliters of whole blood, the information that must be submitted with the specimen is as follows:

Physician's name and address, including ZIP code
Patient's full name, address, and county of residence, with the usual data as to age and sex and, if available, the Welfare Number
The date the specimen was taken
The test required
The Additional Entry in large letters at the top of the form:
FOR MARRIAGE IN .....(city),
.....(state).

The specimen is then sent to the Central Laboratory, Bureau of Laboratories, 16 E. 23rd Street, Baltimore, Md., 21218. Specimens received by noon are reported by 4 P.M. the same day. If, as is often convenient, the physician wishes the report delivered to the patient in person, he must unmistakably authorize this. There is no charge for this test, since it is made for the detection of a communicable disease.

Pennsylvania (and a few other states) authorizes the issue of a marriage license upon evidence of a serologic test for syphilis performed in a state-approved laboratory in another state, *provided* such approval is certified on the Pennsylvania form by an authorized official of the approving Department of Health. For this, of course, the form, if not the specimen, must be sent to the Bureau of Laboratories. Further information is under compilation for publication on this subject, which will in all likelihood be covered in Federal regulations effective July 1, 1969 dealing with clinical laboratories operating in interstate commerce.

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION

ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE

DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily

Tuesday Evenings 7 to 9

355-9300

PATAPSCO AVENUE & FOURTH STREET

Baltimore, Maryland, 21225

MEDICAL CENTER

to be built in

THRIVING SHOPPING CENTER

at

PERRING PARKWAY and McLEAN BLVD.

● All suites on ground floor ●

For information . . . . call

W. C. PINKARD & CO.

5 E. REDWOOD ST. BALTIMORE, MD.

PL 2-4285

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected for possible growth of principal and income.

NO SALES CHARGE

NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

Brentwood Inn

FRENCH CONTINENTAL CUISINE

Smorgasbord Luncheon and Dinner every Tuesday . . . . .

"Home of Maryland's Internationally Famous Wine Cellar" . . . .

We honor all preferred Credit Cards

● *NEW!* Another Dining Room has been added to accommodate our many guests ●

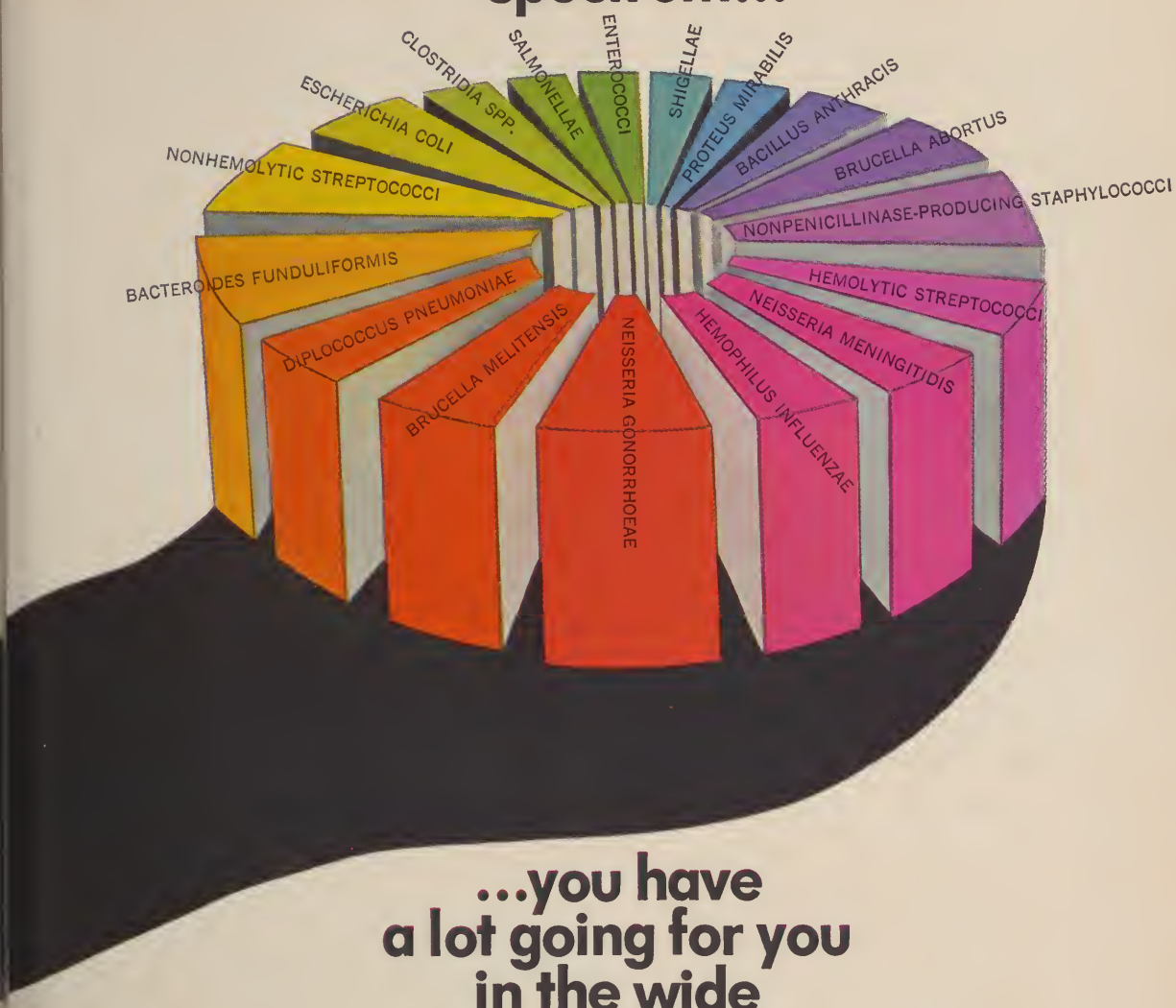
OPEN DAILY & SUNDAY 11 A.M. to 2 A.M.

Fifth Ave. & Brentwood—1 block N. E. of Dundalk and Holabird Ave. 1 mile from Holabird Ave. Exit of Baltimore Harbor Tunnel

We cater to Private Parties, Banquets and Dinners

AT. 5-0520 *Ample Free Parking* BALTIMORE, MD. 21222

With the broad Polycillin (ampicillin trihydrate) spectrum...



...you have a lot going for you in the wide range of bacterial infections.

PRESCRIBING INFORMATION. For complete information consult Official Package Circular. **Indications:** Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis —150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

11·1/2/69 **A.H.F.S. Category 8:12.16**

Polycillin®
(ampicillin trihydrate)

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201

BRISTOL

The penicillin you use like a broad-spectrum antibiotic

now she can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.



Public Enema No.1





n the rewards of sparing your patients the tubes ribulations of unpleasant enemas.

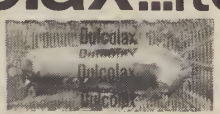
pared to enemas, Dulcolax suppositories are a er and simpler way to empty the bowel. Gone he tubing, the "accidents", and the bruised egos. one suppository, inserted against the bowel wall, ly brings about an evacuation within 15 minutes a hour.

hospital, order Dulcolax for constipation or bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable

bisacodyl



ense from Boehringer Ingelheim G.m.b.H.

Geigy Pharmaceuticals, Division of Geigy Chemical Corporation, Ardsley, New York 10502

DU-6118

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

When Professional Experience Counts

The House In The Pines Staff Is Able and Ready To Serve!



BEL AIRE . . . 5837 Belair Road • CL 4-8800



BELVEDERE . . . 2525 W. Belvedere Ave. • FO 7-9100
Conveniently located 1 block from Sinai Hospital.



CATONSVILLE . . . 16 Fusting Avenue • RI 7-1800



EASTON, Md. . . . Rt. 50 & Dutchman's Lane • TA 2-4000

HOUSE IN THE PINES Nursing and Convalescent Homes offer efficient, round the clock care under the direct supervision of registered nurses, 24 hours a day.

The aged, convalescent and the chronically ill guests enjoy a modern, home-like atmosphere with the most up-to-date medical and therapy equipment at their side.

Complete physical and occupational therapy programs are available. The recreational programs are designed to full-fill the needs and desires of our guests.

Excellent food is served, and special diets catered to, under the direct supervision of our licensed staff dietician.

Physicians orders are followed explicity!

HOUSE IN THE PINES
NURSING HOMES

Your Inspection Invited
Brochure Upon Request


"I feel
so light-
headed..."

She's confused...and frightened. Yesterday, her complaint was a brief spell of dizziness. Next week, she may be troubled by prolonged nausea or tinnitus. The symptom of vertigo is a constant problem in geriatrics, and regardless of origin, duration, and frequency, such episodes can result in severe emotional and physical discomfort for the aging patient.

You can help prevent such problems with

BONINE®

(MECLIZINE HCl)

protects most patients against nausea and vertigo up to 24 hours with a single dose.

Whether the symptoms are due to Ménière's syndrome, labyrinthitis, vestibular dysfunction, or cerebral arteriosclerosis, most patients with nausea and vertigo respond remarkably well to Bonine (meclizine HCl). A single dose usually protects up to 24 hours. In difficult cases multiple daily doses may be necessary for maximum response.

One-a-day dosage costs your patients less. And fruit-flavored Bonine chewable tablets are more convenient to take anytime, anywhere—without water. Side effects are infrequent and mild, even with prolonged use.

Precautions: Although the incidence of drowsiness and atropine-like side effects such as dry mouth and blurring of vision is low, the physician should alert the patient to the need for due precautions when engaging in activities where alertness is mandatory. *Use in women of childbearing age:* In weighing potential benefits vs. risk in women of childbearing age, consider the fact that a review of available animal data reveals that meclizine exerts a teratogenic response in the rat. In one study a dose of 50 mg./kg./day (50 times the maximum recommended human dose) produced cleft palate in 2 of 87 fetuses when administered to the rat at critical times during the first 15 days of gestation. At doses of 125 mg./kg./day, meclizine will produce 100% incidence of cleft palate in the rat. At doses of 25 mg./kg./day, decreased calcification of the vertebrae and relative shortening of the limbs were also produced in the rat, but experts disagree as to whether this is a teratogenic response. While available clinical data are inconclusive, scientific experts are of the opinion that this drug may possess a potential for adverse effects on the human fetus. Consequently, consideration should be given to initial use of a nonphenothiazine agent that is not suspected of having a teratogenic potential. In any case, the dosage and duration of treatment should be kept to a minimum.
Supply: 25 mg. scored tablets.
More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545

Achromycin V
250 mg. capsules

ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481D-9



Your old friend

BELLADONNA

ALKALOIDS & PHENOBARBITAL

HYOSCYAMINE 0.30 mg. ATROPINE 0.06 mg.
HYOSCINE 0.02 mg. PHENOBARBITAL ¾ gr.

Now available in a long-acting capsule . . . . . .

For Sample and Literature
ANN-LEE LABORATORIES, INC.
P. O. Box 377
Randallstown, Md. 21133

Name .....

Address .....

.....
City State Zip

PHEN-BEL

CAPSULES

Your patient no longer has to worry about leaving his bottle of "pills" at home while at work. One PHEN-BEL Capsule in the morning and another at night for "round the clock" action.

The Cost is Reasonable

ANN-LEE LABORATORIES, Inc.

Randallstown, Md. 21133



ANNOUNCING THAT

The GUNDRY SANITARIUM

*Established 1900 * * * Continually Growing and Modernizing*

(1) . . . HAS BEEN ACCREDITED FOR 3 YEARS BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

(2) . . . HAS BEEN CERTIFIED AS A PARTICIPATING HOSPITAL FOR HEALTH INSURANCE UNDER SOCIAL SECURITY (MEDICARE)

The GUNDRY SANITARIUM, a complete psychiatric community, includes a 33-bed Inpatient Hospital for female patients, a Night Hospital for female patients, a Day Hospital for male and female patients, and an Outpatient Department for patients of all ages.

Wouldn't you feel satisfied knowing that your patient is receiving care in a hospital with all these advantages:

- **Treatment is based upon intensive individual and group psychotherapy combined with drug therapy when indicated**
- **All the Doctors are highly trained Psychiatrists**
- **Highly trained Nursing and Medical staff is available 24 hours a day**
- **Environment is warm and homelike.**
- **Protected against fire by approved sprinkler system**
- **Competent medical consultation in all fields is available**
- **Close liaison with the referring physician is maintained**
- **All forms of occupational and recreational activities are offered**
- **Follow-up care in the Day, Night or Outpatient Service**
- **RATES are reasonable; outpatient fees on a sliding scale.**

The GUNDRY SANITARIUM

2 N. WICKHAM ROAD **BALTIMORE, MD. 21229** **Phone 644-9917**

Psychiatric Hospital
licensed by the
State of Maryland

Rachel K. Gundry, M.D.
MEDICAL DIRECTOR

ACCREDITED FOR 3 YEARS BY JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

CERTIFIED AS A PARTICIPATING HOSPITAL FOR HEALTH INSURANCE UNDER SOCIAL SECURITY

Members of MAMA Attend AAMA Convention

The annual American Association of Medical Assistants' Convention was held during the week of October 7, 1968, in Columbus, Ohio.

Representing the Maryland Association of Medical Assistants were the elected Delegates: Gertrude Gillum, president of MAMA; Dorothy Hartel, president-elect of BAMA, and Nell Chaney. Mabel Young also attended as a representative from Maryland, and she assisted as a page in the House of Delegates.

On Tuesday and Wednesday of the week, the MAMA sponsored a hospitality room. The theme chosen to represent a Maryland tradition was the Baltimore Colts. Dressed as cheerleaders in blue and white outfits, the hostesses served miniature sandwiches and beer.

Dorothy Hartel was nominated for the office of president-elect of AAMA, and although Dorothy did not win the election, she was appointed Vice-Chairman of membership in charge of organization. Mrs. Hartel also served on the reference committee of constitution and bylaws, and represented Puerto Rico in accepting its charter as a new association.



At left:
MAMA representatives at the AAMA convention included Dorothy Hartel, Russell Fisher, MD (former advisor and convention speaker), Gertrude Gillum and Mabel Young.



At right:
Cheerleading hostesses in MAMA's hospitality room during the convention in Columbus were Nell Chaney, Dorothy Hartel, Mabel Young and Gertrude Gillum.

of Medical Assistants

Baltimore Association of Medical Assistants Adopts Family at Christmas

The Baltimore Association of Medical Assistants successfully completed its annual Christmas project. The funds collected from the membership and friends were more than sufficient to make a poor family happy at Christmas time. Total collections amounted to $138.50.

Delivery to the family was made on Saturday, December 21, 1968. Two cars were completely filled with clothing, toys, gifts, and canned goods. The family was also given a food certificate for $20 plus $25 in cash.

The family was completely stunned by the quantity of the present, and the eyes of the children would have made each member feel very rewarded for having helped.

A jumbo plastic basket was filled with 20 gift-wrapped presents for the family. The committee had purchased pants, shirts, and underwear, and had filled stockings with candy and various items.

In addition, the committee brought joy to an elderly lady who is bedridden, by purchasing a new robe and slippers for her. She was overwhelmed when presented with the lovely gift-wrapped presents.

Wicomico County Association of Medical Assistants Installs New Officers

At the annual Christmas party of the Wicomico County Medical Assistants the new officers for the year were installed. The officers are as follows:

Doris Ward—President
Judy Terlson—President-Elect
Barbara Hopkins—Secretary
Pat Kelly—Treasurer

BAMA Installs New Officers at the Annual Christmas Party

On December 10, 1968, Eleanor Mainhardt, CMA, installed the newly elected officers of the Baltimore Association of Medical Assistants. The new officers are:

Dorothy Hartel—President
Peggy Bury—President-Elect
Rita Cobry—Vice-President
May Thompson—Recording Secretary
Valerie Hachtel—Corresponding Secretary
Dorothy Walker—Treasurer

During the months of December and January the new committee chairmen were appointed and are as follows:

Rita Cobry—Membership
Eleanor Mainhardt—Nominating
Dorothy Walker—Budget and Finance
Eileen Adams—Registration
Ann Shultz—Public Relations
Thelma Dorsett—Education
Eleanor Mainhardt—Judicial
Peggy Bury—Constitution and Bylaws
Valerie Hachtel—Program
Eleanor Stuck—Arrangements
Margaret Stump—Fund Raising
Lillian Burford—Telephone Contact

(Continued next page)



Newly elected officers of BAMA are *(from left)* Peggy Bury, president-elect; Dorothy Walker, treasurer; May Thompson, recording secretary; Rita Cobry, vice-president, and Dorothy Hartel, president.

Montgomery County Chapter Installs New Officers

On February 12, 1969, the Montgomery County medical assistants held their annual Bosses' Night and installed the new officers. The newly elected officers for the year are:

Frances Whittaker—President
Jean Klopfer—President-Elect
Hazel Wright—Vice-President
Nancy Phelps—Secretary
Margaret Eid—Treasurer

John T. Miller, PhD, Speaks to BAMA

The monthly meeting of the Baltimore Association of Medical Assistants was held on February 11, 1969, at the Medical and Chirurgical Faculty of Maryland. The guest speaker for the evening was John T. Miller, PhD.

Dr. Miller spoke on the "Art of Immunology" and his presentation proved to be interesting and informative to the audience.



Dr. Miller

José Martinez, MD, Speaks to Medical Assistants

At the monthly meeting of the Baltimore Association of Medical Assistants held at the Penn Hotel on March 11, 1969, José Martinez, MD was the guest speaker and presented a very interesting talk on "Radioisotopes."

Dr. Martinez briefly explained the origin of nuclear medicine and the growing importance of this field of medicine. Generally speaking, by the use of radioisotopes in diagnostic purposes the doctor is assisted in his final diagnosis of illness by being told what the patient does not have, rather than what the patient does have. Consequently, radioisotopes become a useful tool by which the doctor can save the patient much expense and many times much discomfort.

During his talk, Dr. Martinez showed slides which illustrated the manner in which radioisotopes are used diagnostically. He also explained the various chemical elements involved in proper scanning and the types of tests now available to the patient.

José Martinez, MD, was born in Alexandria, Egypt, which is now the United Arab Republic. He was graduated from Alexandria University School of Medicine in 1957, and came to Baltimore in 1958. He trained in internal medicine at Church Home and Hospital. He then received his training in nuclear medicine at The Johns Hopkins University School of Medicine and the Oak Ridge Institute of Nuclear Studies. Presently, he is in private practice of internal medicine, as well as associate medical director of The Baltimore Regional Joint Board of Amalgamated Clothing Workers of America Health and Welfare Fund. Dr. Martinez is also director of the Division of Nuclear Medicine at Lutheran Hospital.

Medical Assistants' Week

Each year, for the past three years, the week preceding the annual meeting of the Maryland Association of Medical Assistants has been proclaimed MEDICAL ASSISTANTS' WEEK by the Governor, in order to call attention to the dedicated approach to duty which characterizes the physician's assistant. The desire to help those in distress to the best of their ability, and the increasingly important contributions in the field of education for paramedical workers by this group has earned it the attention and respect of the nation, since it is a national organization.

During this week, members of the Baltimore Association of Medical Assistants donated and operated a coffee and doughnuts bar for the aid and comfort of their physician employers who attended the annual meeting of the Medical and Chirurgical Faculty of Maryland at the Alcazar from April 9-11, 1969. This association of workers in the health field is the only such group approved and endorsed by the American Medical Association.

The week's activities ended with the 9th Annual Meeting of the MAMA which was held at the Holiday Inn on Saturday, April 12, 1969. The business meeting and election of officers were conducted as usual, interspersed with lectures by two prominent physicians. William Kirby, MD, director of Administrator Research, Department of Medicine and Surgery, Veterans Administra-

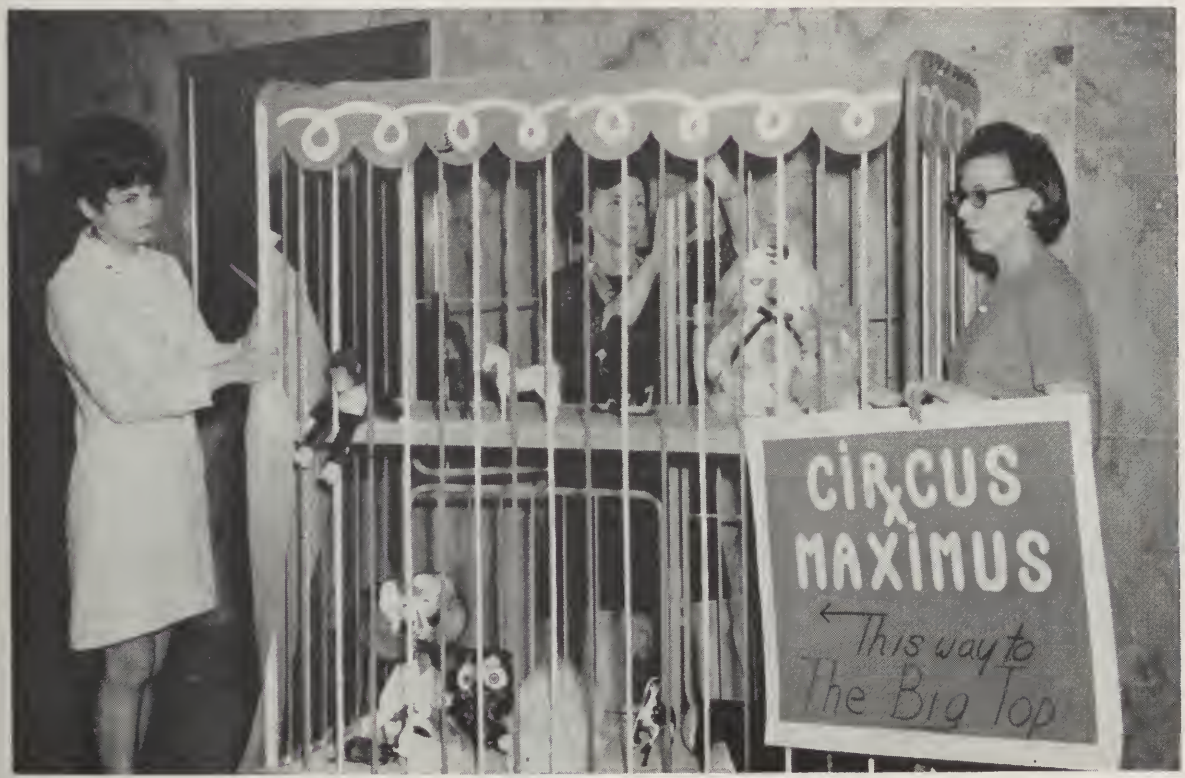
tion, spoke on "Some Approaches to the Medical Care Problem." Otto C. Brantigan, MD, professor of clinical anatomy and professor of surgery at the University of Maryland, lectured on "Help Needed in Surgery."

Mrs. Richard Daniel, Physical Therapy technician at Church Home and Hospital, was installed as President of the association at the banquet which was held following cocktails in the evening. Mr. T. G. Whedbee, Jr., Director of Church Home and Hospital, was Master of Ceremonies at the banquet and Rev. Thomas Subock, of the Baltimore Council of Churches, whose residence is in Annapolis, was Chaplain for the evening.



Barbara Daniel
New President of MAMA

Below:
Barbara Daniel, Ann Shultz and Nell Chaney are pictured busily preparing for MAMA's Annual Meeting, and the Paint and Powder Show, which was held earlier this month for the benefit of Church Home and Hospital.



The State of Maryland

Executive Department

GOVERNOR'S PROCLAMATION

Doctor's Day
March 30, 1969

WHEREAS, Medical men and women labor long hours caring for the sick and preventing human misery and suffering; and

WHEREAS, The horizon is bright with new hopes in the skills and knowledge of those devoted to the area of healing; and

WHEREAS, The world has one of its greatest centers in Maryland for developing and disseminating advanced knowledge in medicine and surgery; and

WHEREAS, With the help of our fine surgeons and physicians, our State has a pioneer plan of giving medical aid to those unable to support their needs; and

WHEREAS, The people of Maryland are grateful to the medical profession for its vital contributions to the health of our population;

NOW, THEREFORE, I, MARVIN MANDEL, Governor of the State of Maryland, do hereby proclaim the 30th Day of March, 1969, as

DOCTOR'S DAY

in Maryland, and I urge my fellow citizens to give special thanks to the many unselfish men and women who practice medicine among us.

GIVEN Under My Hand and the Great Seal of the State of Maryland, at the City of Annapolis, this 11th Day of February, in the Year of Our Lord, One Thousand Nine Hundred Sixty-Nine.

By the Governor:

Marvin Mandel

Blair Lee III
Secretary of State



MRS. HARRY L. BERMAN, EDITOR

Doctors' Day Observances Around the State

Sunday, March 30 was Doctors' Day throughout the State. Each year, one day is set aside to express our appreciation to the physicians of Maryland for their unselfish services.

Carnations and conviviality . . . Bouquets of red carnations were placed in Carroll County General, Harford Memorial, Sacred Heart and Memorial (Cumberland) and the four Montgomery County hospitals by local medical society auxilians. Patients were remembered with tray favors. Luncheons, dinners and dances prevailed over Maryland's countryside.

Prince Georges General Hospital was the setting for a Doctors' Day luncheon, planned by the hospital administrators. Auxilian hostesses presented a red carnation to each physician, while posters in the hospital and local libraries complemented the theme.

On the Eastern Shore Four Counties physicians enjoyed a dinner in their honor; and wives of Harford physicians pooled their talents for a delightful covered-dish dinner.

At St. Joseph's Hospital, Baltimore County auxilians presented a medical book to commemorate the day; while Washington County auxilians presented books to the Wroth Memorial Library.

The Enoch Pratt Library devoted one of its Cathedral Street windows to the medical professional with an impressive display arranged by the Baltimore City auxilians. The metropolitans also contributed their annual check to AMAERF to be divided between the two medical schools.

One of the loveliest tributes on this special day was a remembrance by the Harford County auxiliary. AMAERF memoriam cards were sent to widows of medical society members.

The Woman's Auxiliary to the Montgomery County Medical Society presented a bouquet of red carnations to the four hospitals in Montgomery County; and People's Drug Stores sponsored a cocktail reception at the Indian Springs Country Club in honor of the devoted physicians of the community.



The receiving line at the cocktail reception in honor of the doctors of Montgomery County included (*from left to right*): Mrs. John McHugh, Mr. John McHugh, director of Professional Services of the Peoples Drug Stores; Mrs. Mertin White, wife of the president of the Montgomery County Medical Society; Mr. George P. Burrus, president of Peoples Drug Stores; and Mrs. Burrus; Dr. Gordon Smith and Mrs. Smith, president of the Woman's Auxiliary to the Montgomery County Medical Society.

The MEDICAL and CHIRURGICAL FACULTY of the State of Maryland

ACCIDENT AND HEALTH PROGRAM FOR FACULTY MEMBERS

- ACCIDENT AND SICKNESS TOTAL DISABILITY
- MAJOR MEDICAL EXPENSE
- ACCIDENTAL DEATH AND DISMEMBERMENT

Administered by
THE MED-CHI INSURANCE TRUST

Official Faculty Agent
B. Dixon Evander and Associates

Underwritten by
Hartford Accident and Indemnity Company

Member of
The Hartford Insurance Group
Hartford, Connecticut

For more information detach and mail slip directly to:

MED-CHI INSURANCE TRUST
1211 Cathedral Street, Baltimore, Maryland 21201

*Name*_____

*Address*_____

*City and State*_____ *Zip Code*_____

MEDICAL NEWS

The American College of Gastroenterology, in cooperation with William H. Rorer, Inc., of Fort Washington, Pa., announces the **1969 Rorer Awards Contest for the best papers in Gastroenterology.**

All papers submitted must not have been published previously. They must represent original work in gastroenterology, or an allied subject, and must not have been presented at meetings of any national society.

The First Prize is $500 and a three-year subscription to *The American Journal of Gastroenterology.* The Second Prize is $300 and a two-year subscription, and the Third Prize is $200 and a one-year subscription. The awards will be made at the Annual Convention Banquet of the College in Houston, Texas in October 1969.

All entries must be received no later than June 15, 1969, and should be addressed to the Research and Education Committee, American College of Gastroenterology, 299 Broadway, New York, N. Y. 10007.

* * *

James E. Carson, MD, Commissioner of the Department of Mental Hygiene, has been elected President of the Maryland Psychiatric Society for the 1969-1970 year.

Russell R. Monroe, MD, Professor of Psychiatry of the University of Maryland School of Medicine, has been named President-Elect. Named Secretary-Treasurer is **Gertrude M. Gross, MD,** Director of the Baltimore City Psychiatric Day Center, and newly elected Councilor is **Courtney Clower, MD,** Director of Psychiatric Education and Training of the Spring Grove State Hospital.

* * *

The American Academy of General Practice in Kansas City, Missouri will pay a consulting fee and expenses of qualified consultants to help hospitals and medical schools plan and set up graduate and undergraduate training programs in family practice, according to **R. Neil Chisholm, MD,** Chairman of the Academy's Commission on Education.

Dr. Chisholm said that the consultants will be reimbursed for actual expenses and paid an honorarium of $100 for each day of consultation, with a limit of two days for each visit. He added that educators and practicing physicians who feel they would qualify, and would like to do this kind of work, should contact him through Academy Headquarters, Volker Boulevard at Brookside, Kansas City, Mo. 64112.

* * *

Manuel J. Balseiro, MD, has been certified as a Fellow of the American College of Anesthesiologists.

* * *

Gilbert D. Barkin, MD, was named to the Board of Directors of the International Society of Certified Allergists at a meeting in Mexico City, December 1, 1968.

* * *

Herbert Gross, MD, of Silver Spring and the University of Maryland Psychiatric Institute, was certified by the American Board of Psychiatry and Neurology at its meeting in Chicago, October 7-8, 1968.

* * *

Gerald Gelford, MD, and **David Cromwell, MD,** published an article entitled, "Methysergide, Retroperitoneal Fibrosis and Rectosigmoid Stricture" in the November 1968 issue of *Am J of Roentgenol, Radium Therapy and Nuclear Medicine.*

* * *

Lewis H. Dennis, MD, published a paper entitled, "Alteration of Fibrinolysis and Blood Coagulation Induced by Exercise and the Effect of Beta Adrenergic Receptor Stimulation" in *The Lancet,* December 1968.

* * *

Evan Ragland Farmer, a medical student at The Johns Hopkins University, has been awarded a foreign fellowship

to Friends Hospital in Kisumu, Kenya. Accompanied by his wife, he will have an opportunity to obtain supervised medical experience in developing areas of the world.

His foreign fellowship, and 30 others, were made possible by a grant from Smith Kline & French Laboratories. With the current selection, the Association of American Medical Colleges has awarded a total of 308 fellowships in the last ten years for work and study in more than 50 countries of Africa, Asia, Latin America, and Oceania.

* * *

The Poison Control Center at The Johns Hopkins Hospital has a member of the house staff available 24 hours a day for over-the-phone advice, and for medical treatment.

The Baltimore City Poison Control Centers are: University Hospital, Redwood and Greene, 955-2121 (ask for poison control); Baltimore City Hospitals, 4940 Eastern Ave., 342-0800; The Johns Hopkins Hospital, 601 N. Broadway, 955-5000 (ask for poison control); Sinai Hospital, Greenspring at Belvedere, 367-7800 (ask for poison control).

* * *

Robert H. Kennedy, MD, Former Director of Field Program Committee on Trauma, American College of Surgeons, has received a special Certificate of Commendation from the Division of Emergency Health Services of the U. S. Public Health Service. This special award was presented to Dr. Kennedy at the Annual Meeting of the Committee on Trauma in Baltimore, Maryland on January 24, 1969.

The award was given to Dr. Kennedy "for his sincere interest, professional guidance, contribution in time and skills, dedication and distinguished service in advancing the cause of improved care and treatment of trauma victims." The Certificate of Commendation was signed by William H. Stewart, MD, Surgeon General; Henry C. Huntley, MD, Director of Emergency Health Services; and Joseph K. Owen, MD, Chief of the Hospital and Ambulance Services Branch.

* * *

The New York University Medical Center announced the appointment of **Mathew H. M. Lee, MD,** as Director of the Rehabilitation Medicine Service at Goldwater Memorial Hospital. Dr. Lee replaces Michael Dasco, MD, who resigned after more than 25 years of service.

Born in Hawaii, Dr. Lee received his undergraduate degree from The Johns Hopkins University in 1953, and was graduated from the University of Maryland School of Medicine in 1956 with honors.

* * *

Rex Boland Conn, Jr., MD, has become Director of a reorganized Department of Laboratory Medicine at The Johns Hopkins Hospital. In his new position, Dr. Conn will head the hospital's clinical laboratories, staffed by more than 200 people.

He also accepted an appointment at The Johns Hopkins University School of Medicine as Professor of Laboratory Medicine in a newly created division of the Department of Pathology. Dr. Conn plans to begin work to form a School of Medical Technology, and a residency training program in clinical pathology.

* * *

Walter Modell, MD, chairman of The Merck Company Foundation's six-member selection committee of distinguished scientists, announced the **winners of the 1969 Merck Sharp & Dohme International Fellowships in Clinical Pharmacology.** They are: Jose Luis Diaz, MD, Mexico; Takashi Ishizaki, MD, PhD, Japan; Cesare Sirtori, MD, Italy; and Milan Slavik, MD, Czechoslovakia.

The Fellowship Program, begun in 1964, is designed to help relieve the world-wide shortage of clinical pharmacologists, physicians who have attained expert knowledge through specialized study and who devote themselves to the evaluation of the usefulness and safety of new drugs before they are made generally available to physicians. The program finances up to two years of study in the United States for each appointee. Full tuition, fees, and basic travel expenses are paid. The grants also provide a basic stipend of $500 monthly, plus a family allowance of $100 monthly for a wife, and $50 for one child or $100 for two or more children.

Dr. Slivak, 38, is engaged in research on immunosuppressive drugs at the Institute of Phramacology of the Czechoslovak Academy of Science in Prague. He received the MD degree from Charles University in Prague in 1960 and is working for the PhD degree in Clinical Pharmacology. He will undertake his training in the United States with Dr.

Albert Sjoerdsma, Chief, Experimental Therapeutics Branch of the National Heart Institute in Bethesda.

The purpose of the grants is to spread knowledge of the science of clinical pharmacology around the world. Therefore, the applicants had to promise to return to their own countries upon completion of their training in the United States.

* * *

Lester M. Dyke, MD, who retired last January as director of the University of Maryland Health Service, will go into private practice in Tilghman, Maryland, a small town of 1400 residents, mostly watermen. "I don't think," he says, "those people should have to drive a 25-mile round trip to see a doctor."

There is other evidence that Dr. Dyke—a retired Army Colonel—isn't going in for full retirement. He will remain until June with the Health Service as a part-time staff physician working with his successor and former assistant director, **U. R. Merikangas,** who is now director.

* * *

A new specialty of Family Medicine was officially recognized by organized medicine in Chicago when the Advisory Board for Medical Specialties and the Council on Medical Education of the American Medical Association approved a specialty board in family practice. The medical regulatory bodies met at the Palmer House.

The new specialty, 20th of the profession's primary specialty groups, brings medicine full-circle since the trend toward specialization began after World War II. With the creation of the specialty of Family Medicine, the family doctor himself now can become a specialist in his own right.

* * *

Proposals for revamping the American health care system to improve its accessibility and productivity were made by the national head of Blue Cross.

Speaking at the Detroit Economic Club, **Walter J. McNerney, president of the Blue Cross Association,** proposed the creation at the national level of a "Council of Health Advisors—advisory to the President in matters pertinent to the health and welfare problems of our society. . . ."

* * *

Theodore Cooper, MD, director of the National Heart Institute, has announced the appointment of **Donald S. Fredrickson, MD,** to the post of Director of Intramural Research. In this position, Dr. Fredrickson will be charged with over-all planning, direction, and coordination of the Heart Institute's intramural cardiovascular research programs.

Dr. Fredrickson's research at NHI has earned him international recognition as an authority on fat transport in the circulation, and on diseases of lipid metabolism. Recently, he and his colleagues introduced a new system for using plasma lipoprotein patterns to identify and classify excesses of blood cholesterol and other fats. With it they have demonstrated several new syndromes not previously recognized as separate diseases.

* * *

The American Council of Otolaryngology, a new medical organization, has been incorporated in the District of Columbia to represent the patient care interests of the nation's estimated 6,000 otorhinolaryngologists.

The new Council, which will establish a national office here this year, plans to provide leadership for national, regional, state, and local groups in otolaryngology in order to provide better patient care in this specialty field.

The Chairman of the Board, elected by the organizing committee, is **Jerome A. Hilger, MD,** of St. Paul, Minn. The other officers elected to the Council are: **John E. Bordley, MD,** Baltimore, vice-chairman; **Paul Holinger, MD,** Chicago, president; **Walter P. Work, MD,** Ann Arbor, Mich., vice-president; and **Jack R. Anderson, MD,** New Orleans, secretary-treasurer.



Dr. Bordley

* * *

Harvey L. P. Resnik, MD, has been named Chief of the National Institute of Mental Health's Suicide Prevention Program.

Dr. Resnik, 39, is an internationally known suicidologist and comes to the Institute from Buffalo, New York, where he was director of psychiatry at E. J. Meyer Memorial Hospital. He is on leave of absence as Professor and Deputy Chairman of the Department of Psychiatry at the State University of New York in Buffalo.

* * *

Daniel R. Robinson, MD, medical director for the 11-state southeast region of the Veterans Administration, has been named Director of the San Francisco VA Hospital.

Dr. Robinson came to the Veterans Administration in April 1953, almost 20 years after he received his MD from the University of Maryland School of Medicine. For more than ten years, he has been responsible for VA medical care extended to the 4.5 million veterans in the southeastern states.

Before assuming his present position in July 1969, he was chief of staff of the Indianapolis VA Hospital and director of the Dwight, Ill., and Ft. Howard, Md., hospitals.

* * *

The Montgomery County Board of Education has established a **Community Drug Alert Program.** Several physicians have been scheduled to speak on the panels, the first of which was held on January 13, 1969, at Bethesda-Chevy Chase High School. The success of this first program was reported upon in the **Montgomery County Sentinel.**

* * *

The Board of the Maryland Medical Service, Inc. has re-elected **J. Sheldon Eastland, MD,** to its chairmanship. **Charles F. O'Donnell, MD,** is the new Board vice president. F. Edward Rugemer, secretary; Denwood N. Kelly, president; Edward F. Hassen, vice president, and William C. Flook, treasurer, are the other officers elected.

* * *

Frank T. Barranco, MD, has completed requirements for the American Board of Orthopedic Surgery and has been named a Diplomate of the Board.

* * *

The newly elected President of the Eastern Section of the American Congress of Rehabilitation Medicine is **B. Stanley Cohen, MD.**

* * *

Julius S. Piver, MD, and **John R. Marchese, MD** were recently certified as Diplomats of the American Board of Obstetrics and Gynecology.

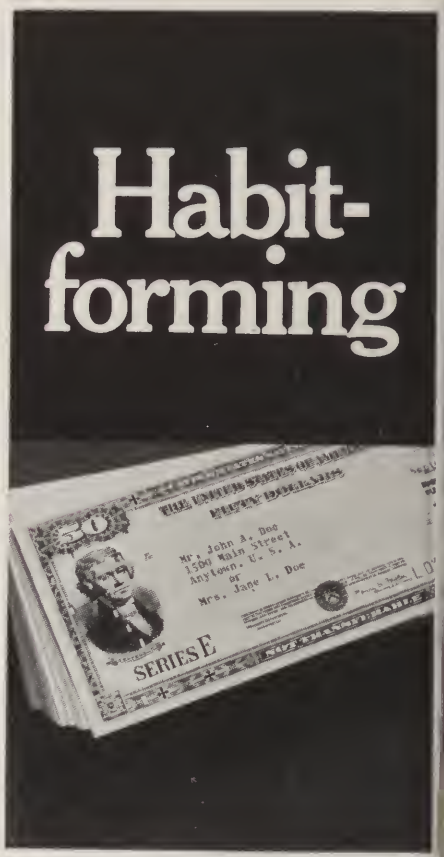
* * *

Doctors John C. Devers, J. Peter Murphy and **Robert W. Zimmerman** participated as speakers on the program of the Southern Maryland Dental Society Postgraduate Clinic, Feb. 21-28, at the Macuto-Sheraton Hotel, Caracas, Venezuela.

* * *

AN EDITOR IS . . .

Adlai Stevenson once said an editor is a man who separates the wheat from the chaff —and then prints the chaff.



When you stack one U.S. Savings Bond on top of another, it becomes a habit that's tough to break and hard to beat. That's because it's so painless. Just tell your employer or banker to set aside a regular amount for you before you have a chance to spend it. Sign up today.

New Freedom Shares

Bonus opportunity for people who buy Bonds through the Payroll Savings Plan or Bond-a-Month Plan — a new U.S. Savings Note called Freedom Shares. It pays a higher rate of interest and matures faster. Get all the facts where you work or bank.

U.S. Savings Bonds, new Freedom Shares



et's be specific about Campbell's Soups...
and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

No two women are quite alike...





and no other oral contraceptive is quite like Ovulen-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

The progestin is distinctive, and for some women this may mean a different clinical response. The Compack® tablet dispenser is distinctive; its functional simplicity makes it virtually patient-proof. The acceptance of Ovulen-21 is distinctive... together with Ovulen®, it is more often prescribed than any other individual contraceptive product currently available.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching.

The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.

References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see Detailed Product Information.

SEARLE Where "The Pill" Began
G. D. SEARLE & CO., P. O. Box 5110, Chicago, Illinois 60680

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous syste depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients wh have previously exhibited a hypersensitivity reac (e.g., blood dyscrasias, jaundice) to phenothiazin Phenothiazines are capable of potentiating centr nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports leukopenia and/or agranulocytosis and convulsi seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmenta retinopathy may be avoided by remaining within recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., drivin Orthostatic hypotension is more common in fem than in males. Do not use epinephrine in treatin drug-induced hypotension. Daily doses in excess 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*— Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism an other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomi Nervous System*—Dryness of mouth, blurred vis constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*— Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urtic type, photosensitivity. *Cardiovascular System*— Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilize including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any signifi disturbance of cardiac rhythm, several sudden a unexpected deaths apparently due to cardiac arre have occurred in patients previously showing electrocardiographic changes. The use of periodi electrocardiograms has been proposed but woul appear to be of questionable value as a predictiv device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl)
25 mg. t.i.d.

for moderate to severe anxie and mixed anxiety-depressi

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J.

What's in a Name?

"What's in a name? That which we call a rose,
by any other name would smell as sweet."

That may have been Romeo's opinion, but so far as the Medical and Chirurgical Faculty's members are concerned no other nomenclature gives off the same aroma of tradition and heritage. In fact, an attempt in 1962 to effect a simplification and modernization of the Faculty name was confounded by tradition lovers who rejected, out of hand, any such effort. Not so, they said, when the Faculty's title was called antiquated and cumbersome and not indicative of dynamic leadership.

The words "chirurgical" and "faculty" in the name may be difficult to spell, and perhaps even harder to define, but in the words of objectors to the resolution before the society's 1962 House of Delegates, it was ". . . presumptuous to tamper with the name of a society which . . . served the State of Maryland with diligence and honor (so) many years."

The Medical and Chirurgical Faculty of the State of Maryland may indeed bear archaic words (the term "chirurgeon" stems from French and Greek and is defined as someone who does something with the hands), but they have been the medical society's sole possession since a special act of the Maryland Legislature in January 20, 1799, created the body.

Actually, Maryland physicians may feel heartened that the original term used to refer to physicians of Baltimore, was not adopted since they were then referred to as The Practitioners of Physic. In comparison, even the word "Faculty", used to connote a person's calling or profession is less redolent of archaic medical practice.

Maryland was the seventh of the original states to establish a state medical society through legislative act and, in fact, the charter met with opposition in its passage through the Legislature and for some years members were in a state of constant apprehension that the legislators would seize upon some pretext to annul it.

It would be interesting to know how the 101 doctors of Maryland in the original corporation came up with the French-Greek title accorded the medical society in 1799, but even that tireless annotator of the medical annals of Maryland from 1799-1899, Dr. Eugene Fauntleroy Cordell, was unable to shed any light on the authorship of the act creating the body. Dr. Cordell notes specifically: ". . . It is a singular fact that in all the researches of the writer, he has never seen or heard of any manuscript relating to the first meeting . . . not a single letter or document was offered making any allusion whatsoever to it." In addition, Dr. Cordell states that the last survivor, Dr. Ashton Alexander, who died in 1855 and who had been the first secretary, never once made allusion to the creation of the charter or the naming of the medical society.

It is noteworthy, however, that at one point in the preamble to the act to establish and incorporate the organized physicians, it is referred to as "a Medical and Chirurgical Faculty or Society of Physicians and Surgeons in the said State . . ."; so it would appear that even then there was a need to define chirurgeons and faculty as surgeons and society, respectively.

If Maryland's medical society bears a more sophisticated cognomen than any other in the union, this is not really unusual for Maryland where things are just a little different than elsewhere. Only in Baltimore, for instance, is the Bachelors' Cotillon spelled without the "i" making it, by definition in the French dictionary, a petticoat rather than a dance figure. But perhaps it is fitting that Maryland's medical society should have a name derived from the Greek like that of the Vice President of the United States whose name became a household word even, if not too many people can pronounce it: Spiro T. Agnew, that is.

Jeanne B. Sargeant


SOC·MED·& CHIRURG·TERRÆ MARIÆ·SIGILL·MENSE·JUNII·A·D·1799 & LIBERT·AMERIC·23°
INSTITUT·
ΠΟΛΛΩΝ ΑΝΤΑΞΙΟΣ ΑΛΛΩΝ ΠΟΛΛΟΥ

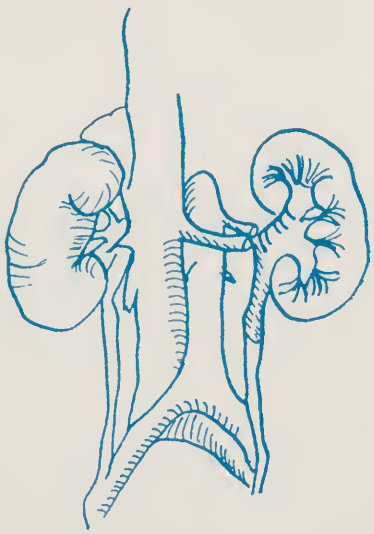
Human Kidney Transplantation:

Renal homotransplantation, although still developmental, has already proven to be an effective treatment for many patients dying of renal terminal failure. During the five years from January 1963 through January 1968, 170 transplants have been performed in 145 patients at the Cleveland Clinic Hospital. Patients receiving kidneys from living related donors can expect at least a 75% one-year survival rate; those receiving kidneys from non-living donors average about a 50% one-year survival. The majority of patients surviving the first critical year live in reasonably good health for at least several years thereafter.

Improvements in immunosuppressive drug therapy, methods for matching donor and recipient, and logistics of organ procurement and preservation are badly needed. If efforts in these areas are expanded on a national scale, renal homotransplantation should become standard treatment for many forms of advanced kidney disease in the very near future.

Present Status

BRUCE H. STEWART, MD
RALPH A. STRAFFON, MD
Dept. of Urology
Cleveland Clinic Foundation
Cleveland, Ohio



and Projected Future

During the past decade the type of treatment available for terminal renal failure has dramatically changed. The use of intermittent hemodialysis and renal homotransplantation has kept many patients alive who were otherwise doomed to an early demise.

In 1954 the first successful human kidney transplant was performed between identical twins at the Peter Bent Brigham Hospital.[1] By 1960, an effective form of immunosuppressive drug therapy had evolved,[2-3] and it became possible to transplant kidneys between related, but non-identical persons.[4-6] As better logistics were developed, it soon became possible to utilize non-living donors on a relatively wide scale,[7] thus eliminating the moral and ethical problems faced in operating upon live, healthy donors.

The latest report of the Human Kidney Transplant Registry lists 1187 primary and secondary renal transplants performed throughout the world.[8] As of February 1968, 170 transplants have been performed on 145 patients at the Cleveland Clinic Hospital; 123 transplants involved non-related, non-living donors, and 47 involved living donors. As a result of this experience it is felt that renal transplantation, although still in the developmental stage, can keep a significant percentage of properly selected patients in good health for long periods of time. Details of currently employed techniques will be discussed, as well as several areas where improvement can and must be made in the near future.

Recipients

Selection—All patients must be in terminal renal failure and require dialysis to maintain life. It is preferable to have a patient under the age of 50, free of other systemic disease, and in whom a reasonable outlook for productive life exists if renal failure can be corrected. Uncooperative or emotionally disturbed patients must, of necessity, be excluded, as careful follow-up studies and treatment are essential for success.

Preparation

(a) *Hemodialysis:* Homeostasis is maintained in all patients by repeated hemodialysis, utilizing either an indwelling Silastic-Teflon arteriovenous shunt,[9] or a surgically created arteriovenous fistula.[10]

(b) *Nephrectomy:* Bilateral nephrectomy, utilizing a midline upper abdominal incision, is done before transplantation whenever possible, for the following reasons: (1) to aid in the control of severe hypertension which is often ameliorated by a renoprival state; (2) to remove a potential source of infection in patients with chronic pyelonephritis; (3) to allow space to insert the transplant in patients with large polycystic kidneys; (4) to provide the patient's own ureter for anastomosis in selected patients; and (5) to provide a recipient in whom subsequent operations with possible complications will not be necessary once transplantation has been done.

(c) *Thymectomy and Splenectomy:* Transcervical *thymectomy* has been carried out by Dr. George S. Crile, Jr., in randomized patients at the time of bilateral nephrectomy. The advantage of thymectomy will not become apparent until immunosuppressive drug therapy is stopped, and the individual's capacity to reestablish an effective system of immunity is thus tested. It is still too early to assess the long-term value of thymectomy in this regard, although to date it, at least, has not caused any increased morbidity.

Splenectomy has been done in many patients in an effort to stimulate the production of leukocytes so larger doses of immunosuppressive drugs can be safely used. However, to date, our results have not yet shown that splenectomy is clearly effective in this regard. The spleens that are removed are now being used for the production of antilymphocytic globulin, which is currently employed in the immunosuppression regimen, as will be discussed later.

(d) *The Waiting Period:* If the patient has a suitable live donor, both donor and recipient can be admitted to the hospital for elective transplantation some two to three weeks after bilateral nephrectomy. If the patient is to receive his kidney from a non-living donor, however, the waiting period may be considerably longer. After recovery from nephrectomy, the recipient is maintained on intermittent hemodialysis and lives outside the hospital, coming in twice weekly for dialysis. These patients live near the hospital so that they can be contacted easily when death of a potential donor seems imminent. This waiting period may last several months, depending upon the availability of a suitable donor. **An increase in awareness of this problem by both the medical profession and the lay public is vital if the short supply of donor organs is ever going to be expanded.**

Donors

Living Donors. At present the best results come when kidneys are taken from carefully matched, closely related, living donors. Major ABO blood group compatibility is vital.[11] A sophisticated method of lymphocyte typing between the recipient and potential donors, developed by Terasaki,[12] has further increased the percentage of success.

Non-Living Donors. Unfortunately, about 75% of patients with renal failure do not have a suitable live donor available. In these cases, kidneys must be obtained from non-related donors dying unexpectedly of other causes. Patients with irreversible cardiac arrests, developing during or after cardiac surgery, have been used successfully. Occasionally, a patient may die in the operating room during an open heart procedure. Since adequate renal perfusion can be maintained with cardiopulmonary by-pass and pump oxygenation until potential recipients can be prepared, kidneys obtained from this source are particularly good. However, transplantation in such cases must be performed as an emergency, allowing selection of the recipient to be based only on ABO blood group matching.

If the potential donor has suffered a massive brain injury, death may be postponed by several hours, or even days, by artificial respiratory support. Such patients can be given fluids intravenously and mannitol to maintain good urinary output. Time permits the selection of the recipient from the patients being maintained on intermittent hemodialysis, based on leukocyte serotyping, as well as ABO blood group compatibility. Transplantation can then be carried out on a more elective basis, but only after death has been declared by the patient's attending physician and the family has agreed to organ donation.

Although matching is not as perfect with non-living donors, there are, nevertheless, some advantages. There is no risk to a living donor, and two kidneys can be obtained from a single donor; thus benefiting two recipients simultaneously (this has been done on 33 occasions to date at the Cleveland Clinic Hospital).

Legal Aspects. In most states the laws covering organ donation are outdated and inadequate, requiring permission of next of kin before transplantation can take place.[13] In 1967, a law was passed in the state of Ohio which gives any individual the right to dispose of his own organs as he himself wishes. It allows that right to take precedence over the wishes of any next of kin, and protects both physician and hospital from liability after transplantation has been performed in good faith.[14] It is hoped that similar legislation will soon be passed in other states, and as a result, more organs will become available for transplantation.

Transplantation

Logistics. Securing suitable non-living donors requires the close cooperation of all services in the hospital. When a patient is gravely ill a member of the renal transplantation team is notified, so that the suitability of the patient as a potential donor can be determined. In general, patients dying from neoplasms (other than brain tumors), septicemia, and known renal diseases have been excluded as donors. When in doubt, surgical exposure and examination of the kidneys has been performed in the operating room after permission has been obtained from next of kin.

The majority of non-living donors have died suddenly in the operating room, the emergency room, or in the intensive care unit (Table 1). Several kidneys have also been obtained from cooperating hospitals in Cleveland and in nearby communities. The method of obtaining and preparing the kidney for transplantation has been presented in another publication.[15]

Table 1

Primary Diseases of Cadaver Donors of Kidneys *

Coronary heart disease	33
Brain hemorrhage or tumor	28
Valvular heart disease	21
Aortic aneurysm	3
Chronic respiratory failure	2
Acute respiratory failure	1
Malignant lesion	1
Renal artery stenosis	1
Total	90

* Both kidneys were transplanted from 33 cadaver donors: nine kidneys were obtained from hospitals other than the Cleveland Clinic Hospital.

In many instances it is obvious at the time of

donor nephrectomy that the kidney is nonviable or anatomically unsuited for transplantation. Factors involved in accepting kidneys for transplantation have included: the type of death (sudden or after prolonged illness), the "warm ischemia time" (time from death until kidneys are perfused and cooled to 4 C), the gross appearance of the kidney, and the ease with which the kidney can be perfused. Histochemical techniques for assessing viability are currently being studied and show great promise. Results of these tests can be available soon after death, and appear to be a sensitive indicator of the viability of the kidney.[16]

There is still a tremendous need to make more kidneys available for transplantation. Since the "warm ischemia time" must be less than one hour, **speed is essential in the salvage of kidneys from non-living donors.**

Technique. The donor kidney is placed retroperitoneally in the iliac fossa of the recipient, as previously described.[17] In most cases the renal vein is anastomosed end-to-side into the external iliac vein, and the renal artery end-to-end into the hypogastric artery. If there is any question about the patency of the hypogastric artery, the renal artery may be placed into the external or common iliac artery, or even into the aorta. If the patient has had repeated dialyses via the femoral vein, the iliac vein may be partly thrombosed and should not be used. The opposite iliac vein or the inferior vena cava are preferable in this event.

The ureter is spatulated and implanted into the bladder by a submucosal tunneling technique.[18] Ureteroneocystostomy has been our procedure of choice because of a lower incidence of leakage (about 5%), and because ureteropyelostomy can then be performed as a secondary procedure to try and salvage the kidney if urinary extravasation occurs. It is interesting to note that the percentage of leakage is much higher when cadaver kidneys are used, and that in at least 50% of these there was evidence of definite rejection of the ureter.

Postoperative Care

Immunosuppression. In addition to the usual supportive measures utilized after any major abdominal surgery, all patients receive continuous immunosuppressive drug therapy postoperatively. Azathioprine (Imuran), in doses from 100 to 150 mg daily, and prednisone (Meticorten), 100 to 150 mg daily, are started immediately after surgery and continued in these dose ranges for at least one week. Thereafter, the dose is gradually tapered off to a daily maintenance of 25 to 150 mg of azathioprine and from 2.5 to 15 mg of prednisone, depending on the level of renal function and the presence of rejection or drug toxicity.

During the past year, antilymphocyte globulin (ALG) has been produced by injecting spleen cells into horses, as described by Iwasaki.[19] The technique has been modified to obtain an immunoglobulin fraction, which is less toxic and is now being given to all patients. The drug is given by intramuscular injection and is started several days prior to transplantation when living donors are employed, and on the day of operation in cadaver donor cases. The current dosage schedule is to administer ALG daily for two weeks after operation; then every other day for two weeks, twice a week for two more weeks, and then once a week for the final two weeks. By combining ALG with azathioprine, we have been able to reduce the dose of prednisone and, hopefully, will decrease the incidence of complications resulting from long-term steroid therapy.

ALG has been used in this fashion so far in 12 patients and, although five have died, rejection has not been a major factor. Eighteen other patients have received ALG as a secondary form of therapy for late rejection crises, and 12 of these patients are still alive with functioning kidneys. Serious anaphylactoid reactions have not yet been observed, and it is hoped that further use of this drug will improve the over-all survival rate.

Episodes of rejection not responding to the above therapy may be aborted by adding actinomycin C, 200 μg weekly, or by giving a short course of irradiation locally to the graft (150R every other day to a total dose of 600R).

Dialysis. After receiving a kidney from a non-living donor, many patients undergo a period of oliguria lasting from a few days to as long as two or three weeks before diuresis ensues and the homograft can maintain homeostasis. Intermittent hemodialysis is usually necessary to support life during this period; most patients require from two to four dialyses (Figure 1). Potassium exchange resin enemas may be necessary to help control hyperkalemia in the early postoperative period. As in any patient with oliguria, extreme care in maintaining fluid and electrolyte balance is important.

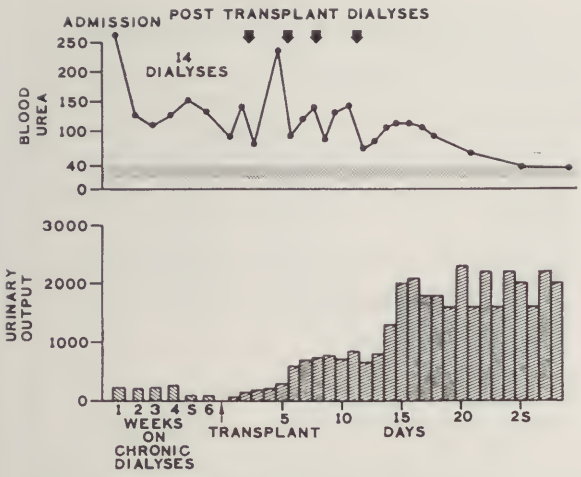


Figure 1. Graph showing postoperative course after cadaver renal homotransplantation, demonstrating transient oliguria.

Complications

The various causes of failure following transplantation are summarized in Table 2.

Table 2
Causes of Failure in Renal Transplants

Cause of Failure	Early (0-3 months)		Late (over 3 months)	
	CD	LD	CD	LD
Nonviable kidney	8	0	0	0
Urine leakage	5	2	1	0
Hemorrhage	5	0	0	0
Vascular complications	6	2	0	0
Rejection	10	4	9	5
Sepsis	3	3	0	0
Agranulocytosis	1	1	0	0
Total	38	12	10	5

CD = Cadaver (non-living) donor
LD = Live donor

Nonviable Kidney. Early in this series, selection of inappropriate cadaver donors led to the transplantation of a number of kidneys already beyond salvage. Postoperative *oliguria* often develops with cadaver kidneys because of the prolonged ischemia time. This may present a real problem in differential diagnosis, as the oliguria may be due to acute tubular necrosis, rejection, ureteral obstruction, or a problem with vascular anastomosis. The management of this problem has been discussed previously.[20]

Sepsis. Infection is a frequent complication and is difficult to differentiate from rejection and equally difficult to treat. It has been the direct cause of failure in six patients and has caused the death of 42 patients. In an attempt to avoid this complication, all patients are kept in reverse isolation during the immediate postoperative period; no drains are used, and the urethral catheter is removed from the bladder in the first 24 to 48 hours, unless the patient has gross hematuria complicating the situation.

Urinary Leakage. The sudden development of oliguria and a suprapubic mass is an ominous sign, and cystoscopy with retrograde pyelography, followed by prompt exploration, should always be considered in such cases. Early evacuation of urine, with secondary ureteroneopyelostomy (using the patient's own ureter or renal pelvis) can result in salvage of the kidney if infection can be prevented. Details of the urologic complications have been discussed in another report.[18]

Hemostasis is difficult to obtain in some recipients, as the bleeding may be a generalized capillary ooze. Administration of protamine sulfate intravenously, 25 to 75 mg during operation, and direct transfusion from a blood donor has been helpful in controlling this type of bleeding. A firm compression dressing is always used during the first 24 hours following operation to minimize hematoma formation around the graft.

Vascular Complications. Venous thrombosis has occurred in two patients. One had developed thrombosis of the iliac vein following multiple cannulization for hemodialysis, and in spite of thrombectomy, thrombosis occurred at the transplant site. In retrospect, it would have been better to use the inferior vena cava for renal vein anastomosis in this patient. A second patient had a simultaneous bilateral nephrectomy and renal transplantation performed, utilizing a non-living donor, and developed profound hypotension for the first 24 hours following operation. It is felt that simultaneous nephrectomy and transplantation as an emergency procedure may be too much for most patients, and this practice has been discontinued.

Massive thrombosis of both artery and vein, secondary to rejection, has occurred in four patients as a result of major ABO mismatching. This was done early in the series when cadaver kidneys were first being used, and this practice has also been discontinued. In one patient, the internal iliac artery thrombosed at the site of an endarterectomy performed to establish adequate blood

flow at the time of transplantation. End-to-side anastomosis into the common iliac artery is now employed in such cases, with less chance of thrombosis.

Rejection and Sepsis. Rejection reactions have been a major cause of failure, mostly in the early postoperative period, but also occurring as late as the second and third year after transplantation. Early recognition and aggressive immunosuppressive therapy is essential in the management of rejection crises. On the other hand, overly vigorous therapy may lead to excessive suppression of the patient's own defense mechanisms, ultimately leading to fatal sepsis. The combination of rejection and sepsis remains a deadly one in many patients, and better methods of immunosuppression are still needed.

Death. There have been 58 deaths among the 105 patients receiving non-living donor kidneys, and 22 deaths from the 47 patients receiving live donor kidneys since the program was started in 1963. The causes of death are summarized in Table 3.

Table 3
Causes of Death After Renal Transplantation

Cause of Death	Early (0-3 months)		Late (over 3 months)	
	CD	LD	CD	LD
Uremia	6	0	5	1
Sepsis	15	8	11	8
Pneumonia	2	0	6	0
Hepatitis	0	0	2	1
Cerebrovascular accident	4	0	1	1
Pulmonary embolus	0	1	1	0
Gastrointestinal hemorrhage	2	1	0	0
Necrosis of bowel	1	0	0	0
Myocardial infarct	0	0	1	1
Unknown	1	0	0	0
Total	31	10	27	12

CD = Cadaver (non-living) donor
LD = Live donor

Results

The over-all one year survival in patients receiving kidneys from related, live donors has been about 75%; patients receiving kidneys from unrelated, non-living donors has been 48%. Fortunately, most of the patients surviving one year have remained in good health for considerable time thereafter. Of 30 patients surviving over two years after transplantation, only five have subsequently died. There are currently 17 patients alive with functioning kidneys over three years, and four patients over four years in good health (see Table 4). The ultimate length of time that a transplanted kidney will survive is of course unknown, but the stability of function in those patients over three years after transplantation has been encouraging.

Table 4. Clinical Status and Length of Survival After Renal Transplantation

Clinical Status of Patients	Length of Survival Time After Transplantation (Years)									
	0-1		1-2		2-3		3-4		4-5	
	No. Patients		No. Patients		No. Patients		No. Patients		No. Patients	
	LD	CD	LD	CD	LD	CD	LD	CD	LD	CD
Excellent	0	4	0	0	2	1	2	3	2	1
Good	1	3	3	3	2	2	1	1	1	0
Fair	0	2	0	3	1	2	0	3	0	0
Poor	1	2	1	0	0	3	0	3	0	0
Total	2	11	4	6	5	8	3	10	3	1

It is gratifying to note the number of patients living and in good health over one year after transplantation. In addition to the patients listed above, 13 patients died between one and two years after transplantation (3 live donors and 10 cadaver donors); four patients died from two to three years after transplantation (no live donor, and 4 cadaver donors) and one patient (living donor) died between three and four years after transplantation. To date, no patient who has lived 4 years after transplantation has subsequently died.

The majority of patients dying over one year after transplantation have done so because of chronic rejection with complicating uremia or sepsis or both.

LD = Live donor
CD = Cadaver (non-living) donor

Patients who have lost a kidney have been placed back on hemodialysis, whenever possible, and considered for a second transplant.[21] To date 21 patients have been so treated, and results indicate that retransplantation may be successful up to 75% of the time, if the first kidney was lost because of technical problems. If the first kidney was lost because of rejection, however, the results are disappointing in general, and these patients are probably best managed by intermittent hemodialysis.

The Future

Immunosuppression. Although techniques of immunosuppression have been developed to a remarkable degree since 1960, further improvement is still needed. Conventional immunosuppressive therapy still cannot prevent rejection in many cases, and if it is pushed too far, the defense mechanisms of the patient are excessively suppressed and overwhelming sepsis ensues. The development of ALG has been of some help, but a superior drug is still needed.

Matching. Not only are better forms of histocompatibility testing necessary, but they need to be more rapidly performed and much more widely available. Tissue typing centers need to be set up in every major area engaged in organ transplantation, with central registries of prospective donors and recipients available to a number of cooperating institutions. In this way, any given donor can be rapidly matched against a large number of potential recipients, with the kidney ultimately going to that recipient most similar to the donor. With the use of computers and newer techniques of communication, it is conceivable that tissue typing could be effectively carried out on a state- or even nation-wide basis, allowing far greater selectivity and, therefore, much closer donor-recipient matching.

Organ Procurement and Preservation. The number of sudden deaths from cerebral and cardiovascular causes in this country far exceeds the number of potential kidney recipients. The majority of these kidneys are irretrievably lost, even though many patients and their families wish to make the kidneys available for donation. Since the kidney must be removed and perfused within one hour after death, it is often too late by the time the family and attending physician become fully aware of the possibility of organ donation. **Anticipation of the problem** in advance, with notification of transplant personnel on time, will make great many more kidneys available and, thus, minimize the tremendous stress and expense borne by recipients who must wait many months for a suitable kidney.

Organ recovery teams are already in existence in some areas, but must be increased both in number and in range. Two kidneys were obtained from a donor 75 miles from the Cleveland Clinic on Christmas Day 1967. The recovery team then transported both kidneys in a small hyperbaric oxygen tank in a police cruiser to the Cleveland Clinic, where simultaneous transplantation into two separate recipients was successfully carried out. Good liaison with the referring physician and with the state police made this possible. In the future, the use of air transportation should make organ transfer over long distances a practical reality.

Improved organ perfusion techniques are now being perfected;[22] it will soon be possible to bank kidneys in a pump-oxygenating machine long enough for tissue typing and viability testing. Optimal preparation of the recipient can then be carried out. Should the best patient for a given kidney reside in a distant locality, air transportation of the patient to the center processing the kidney should be entirely feasible.

Presented at the 13th Clinical Meeting of the Frederick A. Coller Surgical Society, September 28, 1967, New Orleans, Louisiana.

REFERENCES

A list of references will be supplied upon request.

Renal Homotransplantation

PAUL BORMEL, MD
Baltimore, Maryland

I. Historic Background

Concept of transplantation in
Egypt—Sphinx
Greece, Rome—Human head; animal form
Pan
Centurion
Transplantation of leg of Ethiopian to saint
—St. Cosmos and St. Damian—painting by Fra Angelica—St. Marco's Museum, Florence, Italy—1400
Pedicle flap transplant to nose—Tagliocosa
—based upon poem "Sympathetic Slave"—1600
John Hunter—transplanted teeth—1771
Baronio—demonstrated free skin autografting in sheep—1804
Bauer—skin graft exchange between identical twins—1927
Medawar—demonstrated that lymph tissue recognizes and reacts against homologous tissue—1957

II. Terminology of Tissue Transplantation

Old Terminology	*New Terminology*	*Definition*
Autograft	Autograft	Graft in which donor is also recipient
Isograft	Isograft	Graft between individuals identical in histocompatibility antigens
Homograft	Allograft	Graft between genetically dissimilar members of the same species
Heterograft	Xenograft	Graft between species

* * * * *

HETEROTOPIC—A graft in different or unnatural recipient locations.

HOMOSTATIC or ALLOSTATIC—(Functional capacity of tissue)—Tissue from same species but deprived of viability, eg, arterial graft which serves a mechanical function but does not require viability.

HOMOVITAL or ALLOVITAL—Transplants expected to perform their full normal metabolic function after transfer.

ORTHOTOPIC—A graft of any genetic origin that is placed in the anatomical position normally occupied by such tissue.

III. First Successful Homotransplantation of the Human Kidney Between Identical Twins

BY: J. P. Merrill, MD; J. E. Murray, MD; J. H. Hartwell, MD; and W. R. Guild, MD. Peter Bent Brigham Hospital and Harvard Medical School; *JAMA* (**160:277** [January 28] 1956)

Identical Twins Used—(December, 1954)

Preliminary skin homografts were successful.

Blood typing (8 different tests alike).

Preliminary dialysis successful.

Site for transplantation: Disadvantages of renal fossa

a. Requires simultaneous nephrectomy, thus increasing the magnitude of the operation.

b. Necessity of a uretero-ureteral anastomosis with possible stricture formation because of the length of the transplanted ureter vascularized by the renal pedicle—too short to reach the bladder.

c. The upper thigh—site of previous transplants—Requires a skin ureterostomy with possible ascending infection and problems in urine collection.

Advantages of iliac fossa:

1. Allows for short ureteral segment directly into bladder.
2. Normal thermal environment.
3. Gravity drainage of renal pelvis and ureter approaches normal physiological conditions.
4. Easy accessibility to large vessels.

Operation began: 8:15 AM

Vessels prepared for anastomosis by 9:50 AM

Donor kidney brought to O. R.: 9:53 AM

Common iliac artery occluded: 9:53 AM

End-to-end anastomosis between free end of hypogastric artery and renal artery completed: 10:40 AM

End-to-side anastomosis between renal vein and common iliac vein completed: 11:15 AM

Total ischemia of donor kidney: 1 hr 22 min.

Entire kidney became turgid and pink immediately upon release of the arterial clamp.

Submucosal tunnel made for ureter in bladder—urine now flowing.

Total operating time: 3 hr 30 min. (December 23, 1954)

April 2, 1955—Left nephrectomy

June 20, 1955—Right nephrectomy—Because of persistent hypertension, pyuria, and fear of decrease in function to grafted kidney.

IV. Evaluation of the Status of a Graft

1. Clinical
   - — Fever, rapid pulse
   - — White count
   - — Pain
   - — Decline in status
2. Chemical
   - — BUN
   - — Creatinine
   - — Clearance
3. Angiography
4. Isotopes

V. Causes of Failure

1. Transplantation of a non-viable kidney
2. Sepsis
3. Urine leakage
4. Rejection
5. Hemorrhage
6. Thrombosis of the renal artery or vein or both.
7. Agranulocytosis
8. Forty-seven deaths among the 103 patients. In 31 instances, due to uremia or sepsis or both.

VI. Survival Data Selected from Analysis by Barnes of Cases in Kidney Transplant Registry

Donor	*Total Cases*	*Survival*	
		1 yr	*2 yr*
Mother (127), father (50)	177	53	32
Brother (54), sister (48), Other blood relative (12), Dizygotic twin (9)	123	54	52
Living, unrelated person	95	14	9
Cadaver	241	21	14

719 Renal transplants in 672 patients

VII. Technique of Preparation of Cadaver Kidney

Soon after death of the donor—200 mg of Na-Heparin and 500 ml of Mannitol given intravenously.

Artificial respiration and closed cardiac massage started and continued until kidney was removed.

The removed kidney is flushed with 250 ml of warm saline (room temperature), then with a special cold perfusate — 5 C. This rapidly cools kidney.

Kidney then kept cold to 10 C with isotonic saline.

Kidney kept in hyperbaric oxygen (3 atmospheres absolute).

Total ischemic time averages one hour.
("Use of Cadaver Donors," (*BJU* 38, 1966).

Data on Renal Transplants from Living (L) and Cadaver (C) Donors

Year	Number of Transplants		Functioning Grafts		Percentage of Total	
	L	C	L*	C*	L	C
1963	10	9	3 (5)	0 (2)	30	0
1964	5	22	3 (4)	8 (11)	40	36
1965	11	48	10 (7)	20 (24)	91	42
1966 (thru 1-6-66)	3	15	2	7	66	46
Total No. of transplants	29	94	17	35	59	38
Total No. of patients	25	78	17	35 +	68	45

* ( ) = Number of grafts that functioned for more than a six-month period.

\+ Four additional patients are alive without functioning kidneys.

Primary Disease of Cadaver Donors*

Disease	*No. of Patients*
Coronary heart disease	27
Brain hemorrhage or tumor	19
Valvular heart disease	17
Aortic aneurysm	3
Acute respiratory failure	2
Malignant neoplasm	1
Renal artery stenosis	1
Chronic respiratory failure	1
Total No.	71

*Both kidneys used from 23 cadaver donors. Six kidneys obtained from donors in other hospitals.

Causes of Failure in Renal Transplants*

Causes	Early: 3 months		Late: 3 months	
	LD	CD	LD	CD
Non-viable kidney	3	9	0	0
Sepsis	3	3	0	0
Urine Leakage	1	4	0	1
Rejection	2	7	2	6
Hemorrhage	0	6	0	0
Vascular disease	0	4	0	0
Agranulocytosis	0	2	0	0
Primary disease	0	0	1	0
Ureteral obstruction	0	0	0	1
Total	9	35	3	8

* LD, kidney from living donor; CD, kidney from cadaver donor
("Use of Cadaver Donors," *BJU*, 38, 1966).

VIII. Mechanism of Rejection

Kidney is transplanted between different animals or persons. (Homo- or Allotransplant)

It may initially function well for a week or more.

During this time, however, it gradually becomes infiltrated with lymphocytes and plasma cells, develops edema, and shows increasing degree of destruction of renal tubules.

Finally, the clinical features of rejection appear; the secretion of urine diminishes sharply and stops; the renal blood supply is reduced; and in the final phase of rejection, the kidney becomes totally infarcted.
Total time—usually 2 weeks.

General Methods of Treating Rejection Problem

1. Modify the antigenicity of the graft (has not been accomplished).
2. Suppression of recipient's response of immunity.
   a. Irradiation—whole body
      —local to fossa—1 week, 150r for 2 days for 4 treatments
      —to spleen or R.E. system
   b. Splenectomy
      Thymectomy
      Lymphadenectomy (local and distant)

c. Drugs—Type (1) to suppress immune response of recipient, eg, prednisone (100 to 300 mg daily)

d. Drugs—Type (2) which interfere with reaction of antibody with antigen and which reduce the mass of the lymphoid tissue.

1. *Azathioprine* (Imuran)—A derivative of 6-mercaptopurine. This depresses the immune response by acting as an antimetabolite which interferes with the synthesis of protein, including the formation of antibodies (1 to 3 mg/kg).
2. *Actinomycin* C (Catinomycin, Sanamycin)—Acts by attaching to portions of the DNA molecule, thus preventing formation of matching RNA molecule that is one step in the synthesis of protein by the cell (100 to 200 μg/kg, intravenously).
3. *Azaserine*—Inhibits the synthesis of nucleotides (only limited availability of drug).

Another Approach to Rejection Problem

To predict the degree of histocompatibility between donor recipient pairs—

—Leuko-agglutinins
—Lymphocytotoxins

Chronic Rejection

Chronic rejection of renal transplant occurs in a patient receiving immunosuppressive drugs, but treatment is not entirely effective.

Rejection occurs in a subacute manner with little in the way of edema or cellular infiltration.

Vascular lesions predominate which lead to:

(1) Cortical ischemia
(2) Tubular atrophy
(3) Interstitial fibrosis

Clinically—Nephrotic syndrome
Hypertension
Hyperlipemia

Increasing proteinuria means decreasing function.

IX. Problems

1. Rejection
2. Availability of donors
3. Legal
4. Organizational
5. Money

Ethical Problems in Renal Homotransplantation

1. Treatment is still at the experimental stage and is of debatable value.
2. Patient is submitted to a treatment which includes pain, inconvenience of major surgery, risks, and restrictions when the chance of restoring him to normal life is relatively small.
3. Dialysis versus transplantation.
4. Risks to donor: One Kidney
   Short Pedicle
   Post-op complications
5. Legal—Theological Law of Double Effect
   —English Common Law—Doctrine of Necessity

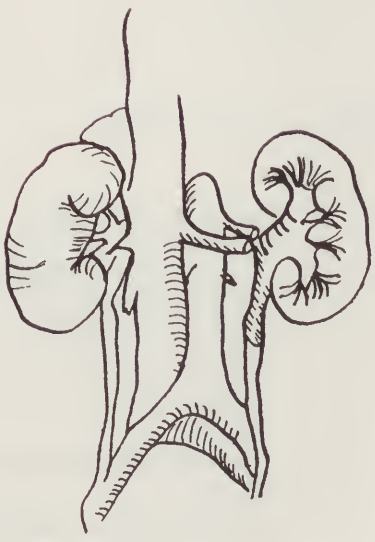
X. Comparison of Kidney Transplantation to Artificial Kidney

	Kidney Transplantation	*Artificial Kidney*
3-month survival	4 out of 5 persons alive	5 out of 5 persons alive
4-year life expectancy	2 out of 5 persons	5 out of 5 persons
Anemia	None	3 out of 5 persons
Hypertension	None	All
Neuropathy skin	None	Almost All
Local infection	None	Most
Diet	No restrictions	Restriction of salt and spices
General infection	Few	Most
Restrictions	Contact sports	Contact sports; dietary
Well-being	Few well	Most feel fatigued

XI. Future Prospects

Kidney Transplantation	Artificial Kidney
Perfect matching lymphocytes	Simplified apparatus
Improved storage	At home—overnight—automatic
Improved immunosuppression	Disposable—few dollars
Improved tolerance	No blood needed
More nation-wide centers	No risk of hepatitis
Heterotransplantation	Better membrane
Complete rehabilitation	Complete rehabilitation

Send reprint requests to: Paul Bormel, MD, 2 East Read St., Baltimore, Md. 21202.



vs DIALYSIS

Organic disease or dysfunction in the aged can often obscure the presence of mental or emotional disorder. The hostile or confused behavior of a geriatric patient who is hard of hearing, for example, is more likely to be attributed to his sensory deficiency than to underlying mental disorder. Consequently, many elderly persons who require psychiatrically oriented supervision and treatment are not receiving it.



The Management of Behavior Disorders in the Geriatric Patient

JOHN SPENCER, MD
Fairland Nursing Home
Silver Spring, Maryland

Nursing homes and related facilities are the cornerstone of extended care services and, as such, are designed for the aged patient who is too well for intensive hospital care, yet too ill to return home. These institutions provide nursing care and medical supervision to more than 700,000 elderly persons admitted ostensibly for physical illness.[1] However, as concluded by Stotsky [1] in his comprehensive review of nursing homes and their procedures, the mental health services of these facilities are not sufficient to cover the total needs of their residents. According to Goldfarb's findings,[2] for example, the vast majority of patients in nursing homes and homes for the aged may suffer significant mental impairment which,

for the most part, has gone unrecognized, and, as a result, untreated. The tendency, therefore, has been to substantially increase the availability of psychiatric services in these extended care facilities and to augment patient care beyond the basic provision of custodial management.

In line with this concept, patients at the Fairland Nursing Home in Silver Spring are offered an integrated course of somatic therapy and goal-directed activity programs such as, recreational, occupational, and physical therapy. With individualized medical and nursing care, such therapy can restore many elderly persons to functional capacities and can either delay or reverse the regressive tendencies in geriatrics who are seemingly beyond rehabilitation. Unfortunately, effective implementation of these rehabilitative programs is impeded for many patients because of their disturbed and often unmanageable behavior. Aggression, withdrawal, confusion or other types of disruptive behavior are overt manifestations of a patient's disturbed mental or emotional status. Psychoactive drug therapy, specifically with the phenothiazine compounds, is useful in controlling the behavioral manifestations of older aged patients.[3,4] We have found that thioridazine (Mellaril) is particularly effective in managing this type of geriatric patient, and the incidence of adverse effects is exceedingly low with this drug. The modulation of disruptive behavior obtained with thioridazine has helped to make patients amenable to the therapeutic programs established for them. As a result, the morale of nurses, attendants, and therapists who must work with these patients has been significantly improved.

The recognition and management of disruptive behavior problems in 65 patients (22 men and 43 women) is described in this report. The age range of these geriatrics was 56 to 95 years (median age was 79 years). They were admitted with various organic disorders (Table I), chief among them being arteriosclerotic, cerebrovascular, and heart disorders. Further evaluation suggested that these physical problems were exacerbated by emotional or mental disturbance. The patients exhibited mild to grossly disturbed behavior (Table II).

Treatment with thioridazine was instituted, with a starting dose (20 to 300 mg/day) individualized for each patient according to his needs. As a patient's behavior was stabilized, his dosage was adjusted to maintain optimal response. Although the maintenance dose also ranged from 20 to 300 mg/day, the majority of patients were both started and maintained on a dose of 20 to 100 mg/day. At the time data on these patients were collated for review, duration of treatment with thioridazine extended from less than one month to almost three years. A wide array of other drugs was employed in treatment, eg, analgesics, hypnotics, antibiotics, vasodilators, and cardiac glycosides. Intermittently during treatment with thioridazine, 18 of the 65 patients were also given antidepressants or other tranquilizers or both.

TABLE I

Diagnosis*

Diagnosis	No. of patients
Arteriosclerosis	27
Heart disease	8
Cerebrovascular Accident	6
Parkinson's disease	6
Hypertension	6
Arthritis	3
Diabetes	4
Hernia	3
Cystitis	3
Carcinoma	2
Blindness	2
Deafness	2
Organic brain syndrome	2
Pernicious anemia	2
Incontinence, Chronic prostatitis, Fracture, Herpes, Nephritis, Osteoporosis, Conjunctivitis, Hemiplegia, Emphysema, Asthma, Cerebral ischemia, Chronic brain syndrome, and Hyperthyroidism	1 each

* One or more in many patients; no medical diagnoses were made in eight patients.

TABLE II

Disruptive Behavior Symptomatology

Symptom +	No. of Patients *
Confusion	36
Agitation	18
Restlessness	15
Noisiness	11
Hostility	11
Uncooperative	10

* 25 patients were described as "senile."
+ More than one symptom in most patients.

Results

Tables III and IV show the results of treatment. Patients were categorized as demonstrating either "marked", "partial", or "no improvement", according to the extent of change in their behavior. "Marked improvement" was characterized

by substantial remission of target symptoms, notably, confusion, agitation, restlessness, and uncooperativeness. Of markedly improved patients the nursing staff noted they exhibited increased sociability and the capacity to cope better with their individual situations. Several judged to be "markedly improved" also tried to help the staff manage other patients. "Partial improvement" reflected relief from some symptoms or reduction of their severity, while other symptoms persisted. Generally, such patients became calmer and less difficult to manage as certain of their behavioral deviations were brought under control. The rating of "no improvement" was ascribed to patients who showed no progress or whose responses to treatment were obscure.

TABLE III

Results of Psychoactive Drug Therapy: Thioridazine Alone in 47 Patients

Results	Number of patients	Per cent of this group (47)
"Marked improvement"	21	45
"Partial improvement"	24	51
"No improvement"	2	4
Total	47	100

TABLE IV

Results of Psychoactive Drug Therapy: Thioridazine in Combination with Various Antidepressants and/or Tranquilizers in 18 patients

Results	Number of patients	Per cent of this group (18)
"Marked improvement"	8	44
"Partial improvement"	8	44
"No improvement"	2	12
Total	18	100

Of 47 patients treated with thioridazine alone (ie, no antidepressants or other tranquilizers), 21 were "markedly improved" after 1 month to 22 months of treatment. After 5 days to 35.5 months on thioridazine, 24 patients were "partially improved". Two showed "no improvement" following 4 days and 2.25 months of treatment, respectively.

Intermittently, 18 patients were given antidepressants or other tranquilizers or both in conjunction with thioridazine. Of these, eight showed "marked improvement" (after 3 weeks to 19.25 months on thioridazine), eight showed "partial improvement" (after 3 weeks to 11.5 months), and two showed "no improvement" (after 1 week and 5.5 months, respectively).

As shown in Tables III and IV, results were slightly better in patients treated with thioridazine alone ("marked improvement", 45%; "partial", 51%) than in those given adjunctive psychoactive medication ("marked" and "partial improvement", each 44%).

Discussion

Recognition of the need to improve upon the basic services of nursing homes and related facilities has prompted increased study of the psychotherapeutic approach in management of the aged.[1] In this approach, rehabilitation, through various programs of somatic therapy, psychotherapy, milieu therapy, and psychoactive drug therapy, is the broad objective. Among the phenothiazine compounds usually employed in such rehabilitative programs, thioridazine stands out as well tolerated and clinically effective in controlling the behavioral manifestations of emotional and mental disturbance in older aged patients.[4, 6]

Our findings are in general agreement with those of other investigators who found this drug useful in the treatment of disturbed geriatrics.[5-10] Of 65 patients exhibiting confused, agitated, restless, noisy, hostile, or uncooperative behavior, 16 were improved ("markedly" or "partially") and 2 were unaffected when thioridazine was administered with other psychoactive drugs; 45 were improved and 2 unchanged when treated with thioridazine alone. As target symptoms were alleviated, the patients became "more cheerful, sociable, and cooperative", appearing to adjust to their new environment with less difficulty. As a result, management was facilitated and the patients were better able to participate in coordinated rehabilitative activity programs.

The obvious benefits accruing from the use of thioridazine in our patients were further enhanced by the relatively low number of side effects observed with this drug. Tolerance of a drug is a

critical factor in geriatric treatment programs, especially with reference to phenothiazine-induced extrapyramidal side reactions. It has been estimated that at least "50% of all patients between 60 and 80 years of age receiving phenothiazine develop extrapyramidal side reactions." [4] Extrapyramidal reactions were not observed in our series of 65 patients who received thioridazine alone or in conjunction with a number of other drugs. Instances of drowsiness were transient and reversible with dosage adjustment. These findings are consonant with those of other clinicians who observed a decreased tendency toward adverse effects with thioridazine.[4, 9]

Since elderly patients routinely receive a wide range of medications at the same time, it was gratifying to note the compatibility of thioridazine when administered simultaneously. Similar findings were reported by Cavero.[10] In his series of geriatric patients, he observed no complications resulting from multiple drug treatment in conjunction with administration of thioridazine.

Summary

Disruptive behavior in 65 geriatric patients at the Fairland Nursing Home was substantially improved with the administration of thioridazine. This drug proved to be an effective adjunct in an integrated program of somatic and milieu therapy. Forty-seven patients were given thioridazine alone; marked improvement was seen in 21, partial in 24, and no change in 2. Of the remaining 18, given thioridazine with intermittent antidepressant or other tranquilizer therapy or both, 8 were judged to be markedly improved, 8 partially improved, and 2 unchanged. As confusion, agitation, and other behavioral manifestations were alleviated, these elderly patients were better able to function within the limitations of their physical and mental capabilities, and over-all management was facilitated. Thioridazine was compatible with a wide variety of chemotherapeutic agents administered to these patients primarily for concomitant physical disorders; no serious side effects were observed in any patient.

REFERENCES

1. Stotsky, B. A.: Nursing Homes: A Review. *Am. J. Psychiat.* **123 (3):** 249-258, 1966.
2. Goldfarb, A. I.: Prevalence of Psychiatric Disorders in Metropolitan Old Age and Nursing Homes. *J. Am. Geriatrics Soc.* **10:**77-84, 1962.
3. Cohen, S.: The Use of Tranquilizers. *Mod. Treatment* **2 (3):** 505-542, 1965.
4. Hamilton, L. D.: Aged Brain and the Phenothiazines. *Geriatrics* **21:**131-138, 1966.
5. Kral, V. A.: The Use of Thioridazine (Mellaril) in Aged People. *Can. Med. Assoc. J.* **84:**152-154, 1961.
6. Jackson, E. B.: Mellaril in the Treatment of the Geriatric Patient. *Am. J. Psychiat.* **118 (6):**543-544, 1961.
7. Judah, L., Murphee, O., and Seager, L.: Psychiatric Response of Geriatric-Psychiatric Patients to Mellaril (TP-21 Sandoz). *Am. J. Psychiat.* **115 (2):**1118-1119, 1959.
8. Felger, H. L.: Thioridazine (Mellaril) in the Geriatric Patient. *Dis. Nerv. Syst.* **27:**537-538, 1966.
9. Lamberton, W. D.: Mental Illness. *Pennsylvania Med.* **70:** 43-44, 1967.
10. Cavero, C. V.: Evaluation of Thioridazine in the Aged. *J. Am. Geriatrics Soc.* **14:**617, 1966.

Preliminary Report on the Dietary Management of Patients With Advanced Carcinoma

Frequently, the main problem concerning patients with terminal types of carcinoma is anorexia, nausea, and vomiting. In an attempt to counteract these symptoms, the resulting malnutrition, and weight loss in three cases of carcinoma, the following diet was devised.

BARBARA A. SOLOMON, MD, MA
Baltimore, Maryland



Methods—Diet Descriptions

Fresh vegetables and fruit juices are given because they contain heat labile vitamin C, vitamin B1, and other minerals and vitamins in higher amounts than in cooked or canned fruits and vegetables.[1, 2] Also, juice is better than solid food, especially for patients with no teeth who find solid food difficult to consume. The Waring Juice Extractor (model VJ1) used in these studies was purchased by the American Cancer Society.

Eight to twelve ounces of juice a day are given —freshly made every day. The juice may be taken during multiple sittings or all at once, depending upon the ability of each patient.

Carrot juice is the main component of the diet because of its sweet taste and high vitamin A content. One package of carrots makes approximately 8 oz of juice. It is mixed with other fresh green vegetables. One half bunch of celery makes an additional 8 oz of juice. One bunch of parsley makes 1 to 2 oz; one half package of fresh spinach makes 4 to 6 oz; and one quarter head of cabbage makes 4 oz of additional juice. Other green leafy vegetables such as lettuce are also used. These vegetables are steamed four to eight minutes, only to tenderize. Potatoes and

corn are steamed 20 minutes for the same purpose.

The only protein foods used are eggs, cheese, nuts, and seafood, because these proteins are more tolerable in patients who are nauseated and prone to vomiting. The fat content of fish compared to meat makes it easier to digest. At the same time, fish is a complete protein and contains all 13 essential amino acids. The fish is boiled or baked.

The menus used may be classified into four diets. The first diet contains vegetable juices taken in quantities of 2 oz every one to two hours. Fresh fruit juices may be included or substituted here. This diet is only used for vomiting patients.

Diet II includes vegetable juices, eggs, and cereal. Soft boiled or poached eggs are given in the morning and cereal at noon or later.

Diet III is comprised of 4 oz of vegetable juice given three times a day between meals. Breakfast includes two eggs and cereal; supper includes mashed potatoes and fresh cooked vegetables which may be blended or puréed to increase tolerance.

Diet IV adds seafoods and salads to the diet. Breakfast includes fruit juice, cereal, or eggs, or both. Lunch contains a salad and a protein such as, yellow or cottage cheese, depending on the ability of the patient to tolerate fat. Fish, vegetables, and potatoes comprise the supper. The fish is baked or boiled. First, deep sea fish is added, then shrimp and crab. The vegetables are steamed. Mid-morning, mid-afternoon, and every evening 4 oz of fresh vegetable is taken. The juice is nutritionally superior to cooked vegetables, and is given in preference to cooked vegetables if there must be a choice.

Case I—47-year-old white female

Diagnosis: Adenocarcinoma of the colon was diagnosed in 1961 and a resection of the colon was done. In 1962, a second bowel resection was done to remove metastatic disease.

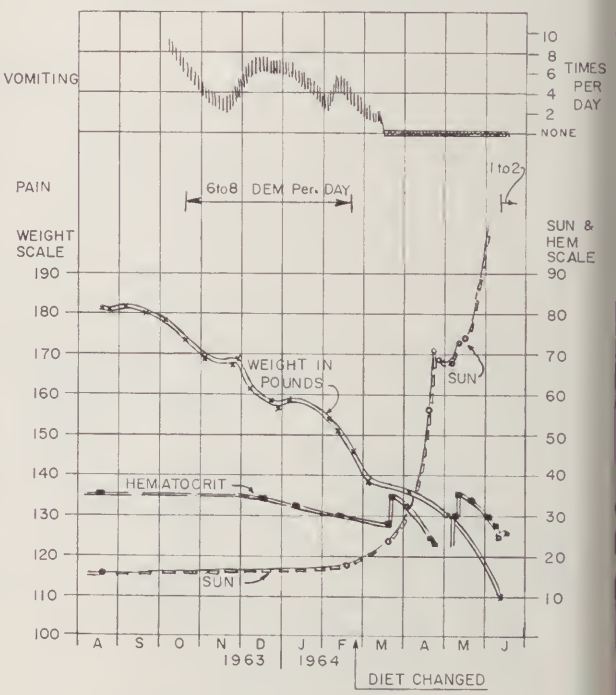
Symptoms: In August 1963, an expanding abdominal mass was noted. Nausea, vomiting, and weight loss were present. Constipation was present, requiring enemas twice a day.

Treatment: In March 1964, Diet I was begun. Two weeks later Diet II was begun; three weeks later Diet III was begun; five weeks later Diet IV was tolerated.

Results: Nausea and vomiting ceased in two weeks; pain abated. In February, she was using 8-50 mg meperidine a day. Pain medication was ceased in three weeks. In April there was no pain. The mass size had decreased to half the size at the time of death. The bowel function improved. In February 1964, she required two enemas a day. By June neither enemas nor suppositories were required. Weight loss decreased. Two months prior to diet change the weight loss was 20 lb. The weight loss two months subsequent to the diet change was 8 lb.

Follow-Up: Uremia was noted ten weeks after the new diet was instituted. The patient was comfortable until death with no nausea, vomiting, or pain. She died in a coma. Autopsy showed adenocarcinoma of the sigmoid, recurrent with local pelvic extension and metastasis to the brain, lungs, liver, diaphragm, peritoneal serosa, uterus, regional lymph nodes, chronic pyelonephritis, arteriolar and arteriolonephrosclerosis, and bilateral ureteral obstruction due to pelvic tumor extension.

Graphic Representation of Case I



Case II—57-year-old white male

Diagnosis: He developed a left neck mass in April 1964. A transitional cell carcinoma was

diagnosed on biopsy. He received three courses of local radiation to the neck area. A primary site was not found.

Symptoms: Anorexia and weight loss occurred. He was 5 feet, 11 inches tall. His weight was 150 lb at the time of the diet change. There was beginning ulceration beneath the left mandible. The dietary regimen was started in October 1965. Diet IV was begun as the patient was able to tolerate this from the start.

Results: The weight loss continued, but at a decelerated rate. The appetite improved, and he was able to eat in greater quantities for five and one half months. The ulceration continued to get worse until December 1965. Then, his strength improved. After this time, the ulceration remained approximately the same until the time of death in April 1966.

Follow-Up: March 1966 he suddenly experienced severe dysphagia, and was admitted to Baltimore City Hospitals where a gastrostomy was contemplated but not done. The patient was maintained on fluids given intravenously, and died April 7, 1966 in respiratory distress.

Autopsy: Microscopic review revealed a poorly differentiated squamous carcinoma invading the left upper neck and left oropharynx. A primary site could not be determined. There was no distant metastasis. The esophagus admitted only the tip of the small finger and, microscopically, revealed fibrous reaction due to radiation. The lungs revealed severe necrotizing bronchopneumonia.

Case III—55-year-old white female

Diagnosis: Adenocarcinoma of the colon with metastasis.

Symptoms: Nausea, vomiting, weight loss, abdominal pain, and constipation occurred. The diet was changed. She was given Diet I for ten days; diet II for four days; diet III for three days; and then diet IV was given.

Results: Subsequently, the nausea and vomiting ceased. The abdominal mass reduced in size, and the abdominal pain was reduced.

Follow-Up: Six weeks after the new regimen was begun, the patient became aware of her diagnosis. She refused all food and medication. In a few weeks she lost 50 pounds and died.

Autopsy: No autopsy was obtained.

Discussion

Cases I and III with carcinoma of the colon will be discussed together because of the similarity in diagnosis. The nausea and vomiting stopped in Cases I and III. The explanation of this interesting effect is not clear. Pain decreased and ceased in one month in Case I, and decreased in Case III. The size of the abdominal mass decreased in both these patients. The explanation for these last two effects is also unknown. In Case II, weight loss decreased probably because his appetite improved and he assimilated more food. His strength also improved, possibly, for the same reason. The improvement in appetite may or may not have been due to improved vitamin B or other vitamin combination intake.

Summary

A dietary regimen which is nutritionally superior and more suited to the needs of patients with terminal carcinoma, in that it is liquid and better tolerated, is presented. It also may make this type of patient more comfortable and stronger for a given period of time. A more intensive and controlled study would be necessary to determine if length of life could actually be prolonged.

REFERENCES

1. Kleiner, Isreal S., PhD, and Orten, James M., PhD: *Biochemistry,* The C. V. Mosby Company, 1962.
2. Wooster, Harold A., Jr., and Blank, Fred C.: *Nutritional Data,* H. J. Heinz Company, 1950.

Send reprint requests to: Barbara A. Solomon, MD, 8427 Old Harford Rd., Baltimore, Md. 21234.

Sarcoma Botryoides

H. MELVIN RADMAN, MD
Baltimore, Maryland

Several years ago, unusual findings were reported in a patient with a huge abdominal mass. It was thought that the tumor was not associated with disease of the genital system, but rather represented an example of primary omental sarcoma. Most authorities would agree that an accurate clinical or pathological diagnosis is difficult in such an entity. Subsequent events proved the validity of this contention.

From time to time, diseases that produce abdominal or pelvic masses have been confused with gastrointestinal maladies, pelvic bone, or urinary tract pathology. Conversely, it has been shown that entities which produce signs not referable to the genitalia are, in reality, diseases of the uterus, tubes, or ovaries. The following data is such an example. With the expulsion of a polypoid mass which proved to be similar, histologically, to the abdominal masses, it would appear that the over-all picture of the disease in this patient was that of a mixed mesodermal tumor. At first, the lesion in the peritoneal cavity seemed to be primary, but later was found to be the secondary extension of a uterine tumor that had not yet been discovered. Lebowich and Ehrlich,[1] with an exact standard of classification, believe that heterologous tumors are rare, and should be reported whenever encountered.

Morehead and Bowman [2] state that those tumors are not uncommon; they contend that a thorough examination of each specimen would yield more examples. An analysis of the literature concurs with the former opinion, as there are only 295 cases reported to date.[1-11]

The factors that make this case presentation of interest are (1) The appearance of what proved to be a secondary lesion as an apparent primary abdominal mass; (2) The lack of genital signs and symptoms that would lead one to believe that the disease was, in reality, of the uterus; (3) The survival of the patient for three years without other gross evidence of extension, invasion, or metastases; and (4) The addition of another case of mesenchymal tumor to the literature.

Case Report

Mrs. S. G., a 32-year-old white woman, sought medical advice because she noticed a progressive enlargement of her abdomen. This was associated with lower abdominal pain. The symptoms seemed to be more marked in the last months. The patient had been married about three or four weeks; she denied the possibility of a pregnancy. Her menses had begun at 14 years of age, appeared every 28 days and lasted four days. There was no history of amenorrhea, metrorrhagia, or menorrhagia. There were no associated gastrointestinal symptoms, but she did have occasional episodes of frequency of urination. She was aware of the mass in her abdomen, and felt that it had become progressively larger. The family and past histories were irrelevant. However, one sister had had a hysterectomy for fibroids several years ago. The general physical examination revealed a well-nourished white woman, not in acute distress. The secondary sex characteristics were well developed. There were no positive somatic findings, except for the mass in the abdomen. This mass was hard, regular in outline, and appeared to arise from the pelvis. The tumor seemed to be mobile, was not tender to the touch, and extended to the level of the umbilicus. Fetal heart tones were not heard, and fetal movements could not be elicited. A pelvic examination revealed a marital outlet. Bartholin's gland, Skene's duct, and urethra had no abnormalities. There was no cystocele, rectocele, or prolapse. The cervix was clean and appeared to be nulliparous. The abdominal mass palpated previously seemed to arise from the pelvis and, apparently, was continuous with the uterus which could not be felt separately. There was some slight fullness in the cul-de-sac but no palpable pathology in either adnexal region. Despite the lack of signs or symptoms of pregnancy, a radiological examination of the abdomen was done. This failed to show evidence of a fetal skeleton or any areas of calcification. Both psoas muscles and kidneys were not well demonstrated because of the soft tissue shadow produced by the mass. The radiological report stated that there was a large mass present of undetermined origin. The cytological smears revealed no evidence of malignancy. The hemogram showed 11.3 gm of blood, or 78.0% hemoglobin, and 38 ml of blood hematocrit. The erythrocyte count was 4,210,000 per cu mm. There were no other significant findings.

The preoperative diagnosis was multiple myoma of the uterus. Under a general anesthetic, the abdomen was explored through a low transverse muscle cutting incision. Upon entering the peritoneal cavity, a single large tumor was found lying free and unattached, save by multiple omental vessels. The uterus, tubes, and ovaries were normal in size and contour. There were no other pathological lesions in the pelvis, and no evidence of tumors of the uterus. The omental attachments of the tumor were doubly ligated, and the large mass was removed without difficulty. Further exploration of the abdominal and pelvic viscera failed to reveal significant findings. The patient's postoperative course was uneventful. She was discharged on the eighth postoperative day.

The surgical pathological report of the specimen removed was as follows. The specimen consisted of a flat, lobulated, yellowish white tumor weighing 1,950 gm. It measured 20.0 x 18.0 x 8.0 cm. The surface was covered by dilated blood vessels. The mass was firm in consistency. On section the cut surface was homogenous, yellow-white-pink in color, and fleshy of rather hard consistency. Microscopic section revealed the typical whorl-like appearance of a myoma with areas of degeneration. Final diagnosis was degenerating parasitic fibromyoma.

The patient re-entered the hospital on November 14 with a complaint of lump in the abdomen of one month's duration. She was then 33 years of age and married for one year. Following her initial operation she was seen on January 4, 11, March 24, June 22, September 21, and October 5, 1961. On each occasion the pelvic examination revealed no palpable pathological findings in either the tubes, ovaries, or uterus. On October 20, 1961, she complained of abdominal pain. There was some fullness in the left adnexal region; none on the right. She was thought to have pelvic inflammatory disease and, therefore, was given antibiotics for four days. The symptoms and the fullness in the fornix disappeared. However, on November 3, 1961, the patient again complained of pain in the abdomen. The menses were still regular. The last period occurred October 29, 1961. There was no other relevant information. The general somatic examination revealed no positive findings. Palpation of the abdomen revealed that the liver, spleen, and kidneys could not be felt. There was a well-healed transverse scar in the lower abdomen, and an irregular hard and somewhat fixed mass extending from the pelvis to the level of the umbilicus. The pelvic examina-

tion revealed a marital outlet. The Bartholin's gland, Skene's duct, and urethra revealed no abnormalities. There was no cystocele, rectocele, or prolapse. By vaginal examination, a mass was found closely adherent to the uterus. The mass seemed to be more developed on the left than on the right, and continuous with that felt in the abdomen. The rectovaginal examination gave no additional information.

On November 15, 1961, under general anesthesia, the abdomen was opened through the previous transverse scar. Multiple firm masses with blood supply from the omentum were encountered. The vessels were clamped and the tumors removed. Areas of the bowel, particularly many of the appendices epiploicae, were involved in the disease process. The pelvic cavity showed no evidence of disease or abnormality of the uterus, tubes, or ovaries. The postoperative course was uneventful. She was discharged from the hospital within one week.

The surgical pathological report on the first tumor was that of a parasitic fibroid. However, as the findings unfolded, it became apparent that the original diagnosis was misleading. A re-evaluation of the microscopic sections showed some evidence of what now is interpreted as mitotic activity compatible with sarcoma. The surgical pathological report of the second specimen revealed: two specimens labeled multiple tumors attached to peritoneal surfaces, multiple peritoneal tumors and scar tissue. The first specimen consisted of four large rounded tumors measuring 6.0 cm, 7.0 cm, 9.5 cm, 5.0 cm in diameter and weighing together 1150 gm. All four tumors were firm in consistency, covered by a smooth, yellowish-pink, translucent capsule. On section, three of the tumors revealed a uniform yellowish-tan, shiny, slippery cut surface. The fourth one showed a slight brownish discoloration in the center and it was slightly firmer in consistency. The second specimen consisted of eight additional tumors measuring 1.5 to 3.0 cm in diameter, but otherwise identical to the previously described tumors. Diagnosis: Multiple tumors attached to peritoneal surfaces; all show a similar appearance, that of sarcomata, with one showing extensive necrosis.

For the first three months following the second operation, the patient received 2320 R cobalt 60 teletherapy over the anterior and posterior pelvis, anterior upper and lower abdomen, and the posterior upper and lower abdomen. In the ensuing 14 months, there were no palpable abdominal or pelvic masses. She felt well, gained weight, and had no complaints. Fifteen months after the operation, she again developed lower abdominal and pelvic masses. A few months later, she complained of a protrusion from the vagina, and expelled a large polypoid mass without bleeding or pain. The surgical pathological report of this tissue revealed: a polypoid cellular tumor containing many newly formed vascular spaces, many of these filled with blood. There was some myxoid tissue present and a few endometrial glands. The cells had ovoid or spindle-shaped nuclei, and a few were anaplastic. The tumor appeared to rise from mesodermal tissue. The diagnosis was Botryoid Sarcoma.

Comment

After the patient developed additional abdominal masses and a second operation was done to remove them, it became apparent that the original tumor was not a parasitic fibroid. The most common conditions of the omentum such as, mesenteric cyst, inflammatory tumors, torsion or traumatic injuries had to be considered. However, the recurrence and extension, as well as the microscopic evidence of the tissues removed at both operations, led to the diagnosis of sarcoma. For two years in which the patient was followed, there was no symptomatology to the genitalia. In addition, a thorough exploration of the pelvic organs had been made at each laparotomy, and no evidence could be detected of uterine, tubal, or ovarian involvement. Therefore, the tumor masses were assumed to arise as a primary lesion from the omentum.

According to McDonald's criterion, it was believed that the abdominal mass found in this patient represented one in less than 100 reported examples of primary omental sarcoma.[12] In 1927, he stipulated a set of circumstances whereby a patient with an abdominal mass could be considered suffering from a primary omental malignancy. Those specifics consisted of (1) No evidence of disease elsewhere in the body; (2) The removed tissue must show microscopic evidence of malignancy; and (3) There must be recurrence, extension, or metastases.

When the polypoid mass was expelled from the vagina, the requirements were nullified. The surgical pathological examination of the growth revealed elements of a mixed mesodermal tumor, and, thus, the true nature of the disease was real-

ized. The clinical course of the patient substantiates Wills' theory concerning primary tumors, ie, that a growth must not be considered primary unless there is complete evidence that it did not arise from an unsuspected tumor elsewhere.[13]

Although there are approximately 300 examples of mixed mesodermal tumors in literature, most authors consider them to be rare. Herbut classifies them in three groups dependent on location.[14] In early childhood, they may originate in the vagina. They are seen to arise from the cervix, in active sex life. While in the menopause, the usual site is the body of the uterus. There have been occasions when the cervical growth has been observed in the menopausal woman. Similarly, the corporeal growth has been found in the active menstrual life.

The unusual train of events in this case history is of interest. It would not have been logical to remove the uterus, tubes, or ovaries at either operation since there was no evidence at first that the disease originated in those organs. Sarcomatous lesions notoriously mestastasize primarily by hematologic spread and, secondarily, by the lymph channels and by direct invasion. The vast interchange of blood through the vessels between the uterus and adjacent viscera and peritoneum is well known. The interchange might account for the appearance of a large metastatic tumor before the discovery of the primary lesion. Otherwise, the appearance of a secondary lesion as a primary finding remains unexplained.

REFERENCES

1. Lebowich, R. J., and Ehrlich, H. E.: Mesodermal Mixed Tumors of Corpus Uteri: Report of Case with Review of Literature, *Surgery* **10**:410, 1941.
2. Morehead, R. P., and Bowman, M. C.: Heterologous Mesodermal Tumors of the Uterus: Report of a Neoplasm Resembling a Granulosa Cell Tumor, *Am J Path* **21**:53, 1945.
3. Carter, E. R., and McDonald, J. R.: Uterine Mesodermal Mixed Tumors, *Am J Ob Gyn* **80**:368, 1960.
4. Corscaden, J. A., and Singh, B. P.: Leiomyosarcoma of the Uterus, *Am J Ob Gyn* **75**:149, 1958.
5. Edwards, D. L., et al: Mixed Heterologous Mesemchymal Sarcomas (Mixed Mesodermal Sarcomas) of the Uterus, *Am J Ob Gyn* **85**:1002, 1963.
6. Glass, M., and Goldsmith, J. W.: A Review of Ninety-four Mixed Mesodermal Tumors of the Uterus (with a report of an additional case), *Am J Ob Gyn* **41**:309, 1941.
7. Hardy, J. A., and Moragnes, V.: Mesodermal Mixed Tumors of the Body of the Uterus (report of two cases), *Am J Ob Gyn* **63**:307, 1952.
8. Krupp, P. J. Jr., et al: Malignant Mixed Mullerian Neoplasms (Mixed Mesodermal Tumors), *Am J Ob Gyn* **8**:959, 1961.
9. Lauraine, A. R., and Monroe, T. C.: Mixed Mesodermal Sarcoma of the Corpus Uteri Associated with Bilateral Thecoma, *Am J Ob Gyn* **78**:613, 1959.
10. Marcella, L. C., and Cromer, J. K.: Mixed Mesodermal Tumors: A Report of 11 Cases, *Am J Ob Gyn* **77**:275, 1959.
11. Radman, H. M., and Korman, W.: Mixed Mesodermal Tumors of the Uterus, *Am J Ob Gyn* **80**:1115, 1960.
12. McDonald, A. L.: Sarcoma of Omentum, *Arch Surg* **14**:1295, 1927.
13. Wills, R. A.: *Pathology of Tumors,* London: Butterworth and Co., 1948.
14. Herbut, P. A.: *Gynecological and Obstetrical Pathology,* Philadelphia: Lea and Febiger, 1953.







As an area of special interest, pediatric surgery has developed primarily for two reasons. The first of these is the unique nature of congenital anomalies which occur in the newborn infant and which, if not recognized and immediately treated, will result in death of the baby, or a severely debilitated child. The second reason has been a gradual realization that the physiological responses of a baby are quantitatively and qualitatively different from an adult and that dramatic changes can occur with greater rapidity during the operative and postoperative care of an infant. It seems reasonable, therefore, that an extended experience with these problems is essential for proper surgical care of an infant. We propose to focus attention upon the second of these two general problems, namely the quantitative and qualitative management of the postoperative infant.

Postoperative Management of Infants

J. ALEX HALLER, MD
Robert Garrett Professor of Pediatric Surgery
Division of Pediatric Surgery
Department of Surgery
The Johns Hopkins Hospital and
University School of Medicine

Postoperative Care

Postoperative care of the infant presents the single greatest challenge in pediatric surgery, for the margin of error is small, and without reliable monitors, may be easily exceeded. Lability has been cited as an outstanding characteristic of the response of infants to stress and trauma. For this reason potential dangers are constantly present, are varied in number, and, therefore, invite the development of specialized techniques for their management. This potential for rapid change requires that the utmost vigilance be exerted to detect subtle signs that may indicate more serious alterations in an infant's condition.

All patients who are admitted to our infant Intensive Care Unit in The Johns Hopkins Hospital are followed on fluid and electrolyte flow sheets with balance calculations every six hours or less. The important features of this flow sheet are serial measurements of central venous pressure, total serum solids, hematocrit, urinary specific gravity, and serum electrolytes, together with precise recording of all fluid intake and output and daily body weights. An infant's vital signs and clinical response remain the most important criteria of satisfactory maintenance of homeostasis.

Our monitoring routine in infants is shown in Table I. It will be noted that this gives a continuous picture of the patient's condition and documents any serial changes which may occur. Since none of these observations requires elaborate equipment, they should all be readily accessible to all physicians, especially in an intensive care area. When coupled with the determinations of serum electrolytes, they offer a very precise guide to therapy.

TABLE I

MONITORING ROUTINE IN CHILDREN

	Central venous pressure
	Total serum solids
q 6 hr	Hematocrit
	Urine specific gravity
	Intake
	Output
Daily	Body weight
	Serum electrolytes & urea N_2

Urinary Output

In older children, urinary output is usually a reliable index of intravascular volume and renal perfusion, but in the newborn infant, both volume and specific gravity of the urine may be misleading. A newborn infant, and especially a premature infant, is limited in his ability to increase volume and to concentrate urine. Urinary specific gravity in this age group may, therefore, remain low in spite of serious, inadequate water intake. On the other hand, congestive failure may develop with overhydration since a relatively low glomerular filtration rate may limit the renal response in such situations and not be immediately detected. Urinary output, then, is a very valuable index of adequate intravascular volume and hydration only of serial determinations are carefully recorded and the limitations of the immature kidney recognized.

Central Venous Pressure

We have found a serial determination of the central venous pressure the single most helpful measure of homeostasis in the postoperative infant. The value of central venous pressure as a reflection of an adequate functional blood volume has been widely recognized. Many standardized techniques have been developed and are important additions to the regimen of postoperative care in older children and adults. It is somewhat strange, therefore, that adaptation of techniques for central venous pressure measurement in neonatal surgery has remained limited. This has been due primarily to technical restrictions imposed by tiny structures. The threats of overhydration and excessive transfusion, ever-present dangers in a tiny infant, are greatly minimized with serial observations of central venous pressure.

In the absence of cardio-respiratory problems, serial central venous pressure determination is a direct reflection of effective cardiac filling. Under these circumstances, it is safe to assume that a decreased central venous pressure is indicative of an inadequate central blood volume, but if the central venous pressure is normal, some other cause must be found for inadequate cardiac output and peripheral perfusion.

The insertion of a catheter for central venous pressure determinations may appear difficult in the newborn infant because of a scarcity of satisfactory sites for its insertion. It must be emphasized that the catheter tip must lie in the central venous pool if it is to reflect accurately the filling pressure of the right heart. The most common site for the insertion of a peripheral venous catheter, the sapheno-femoral junction at the groin, has been shown to be a poor choice for the insertion of a central venous monitoring catheter. Although the reliability of the inferior vena caval pressure as an indicator of effective cardiac filling has been questioned, recent experimental work would suggest that it is accurate as long as the intra-abdominal pressure remains normal. Many operative procedures require abdominal exploration, and many infants in the postoperative period become moderately to severely distended. Because of this concern about the changing intra-abdominal pressure, studies were initiated in our laboratories to evaluate the significance of these clinical observations and concerns. As shown in Figure I, when the intra-abdominal pressure was elevated by instilling air under pressure, the inferior vena caval pressure, measured through an inlying catheter, rose concomitantly, but a similar monitoring catheter in the superior vena cava continued to measure the normal central venous pressure. In every instance any increase in intra-abdominal pressure was reflected immediately by a corresponding rise in inferior caval pressure, while in no instance was there an associated fluctuation in superior caval pressure. These experimental observations have been extensively substantiated in a number of clinical situations. It, therefore, seems certain that any degree of abdominal distention will interfere with accurate estimations of central venous pressure via the inferior vena cava.[1]

It has proven technically difficult to insert a small catheter through the antecubital fossa into the superior vena cava and has proven to be difficult to insert a catheter directly beneath the clavicle into the subclavian vein without producing a pneumothorax in the infant. Therefore, these otherwise satisfactory adult techniques have been abandoned, and a technique for cannulation of the jugular vein has been standardized in our surgical unit.

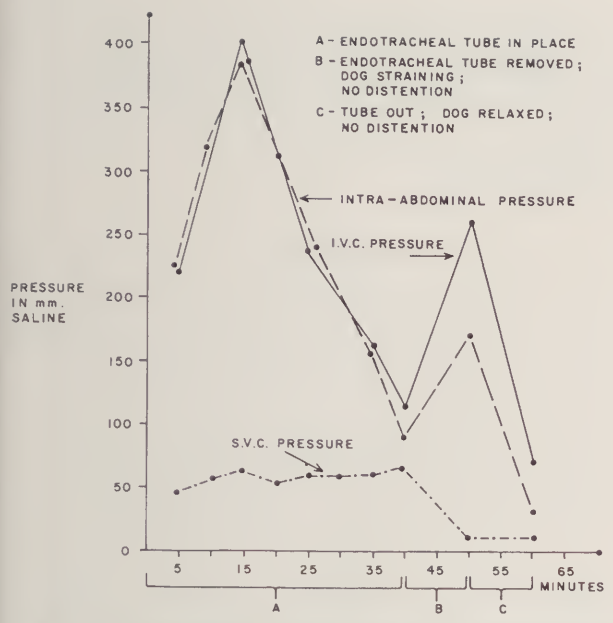


Fig. 1. Relationship of inferior vena caval (IVC) and superior vena caval (SVC) pressures to alterations in intra-abdominal pressure.[1]

The external jugular vein is readily accessible and is usually of sufficient caliber to allow insertion of a suitable Silastic catheter. The presence of a cannula in the neck of an infant offers no hindrance either to his movement or to his management. Rarely have we found it necessary to use the internal jugular vein in the very small premature infant. Cannulation of the internal jugular vein is not a procedure for the inexperienced and should only be used when other routes are not adequate.

A large Silastic catheter may be introduced into the central venous pool using a cutdown technique over the external jugular vein of the infant. Although air embolization might be considered a potential hazard, none has been encountered. Silastic tubing has been employed as catheter material since it diminishes the risk of thrombosis and allows prolonged use. A constant infusion pump, such as the Harvard unit, allows administration of small, precise quantities of parenteral fluids over long periods. The other significantly valuable aspect of central venous catheterization is that it constitutes a dependable means of serial sampling of venous blood. It this way, blood electrolyte and blood gas determinations can be carried out at indicated intervals without venipuncture or capillary sticks.

Normal values for right atrial and central venous pressure are the same in the infant as in the adult, although there are some increases in fluctuations associated with infant respiration and crying. The most important concept in central venous pressure monitoring is that the over-all trend in serial determinations of the pressure, rather than any isolated observation, is the critical factor in judging response to treatment. We have described in detail a satisfactory technique for establishing a central venous pressure monitoring setup in infants.[2]

Determination of Total Serum Solids

The total serum protein content and concentration is an accurate reflection of the relative state of hydration and the level of serum proteins. This measurement is particularly useful in situations associated with massive fluid and protein losses, as for example, in burns or in the postoperative period when there has been extensive soft tissue injury. When this determination is combined with urinary output and a careful measurement of fluid intake, a very precise assessment of intravascular concentrations is available.

With the introduction of a small accurate hand refractometer, an index of total serum solids can be determined from two small micro-hematocrit tubes. The measurement of total serum solids, coupled with simultaneous determinations of hematocrit and venous pressure, provides considerable insight into whether the patient requires water, plasma, or blood replacement at any particular moment. Such data are particularly valuable when one is uncertain whether oliguria, which so often follows trauma and surgery, is due to primary renal damage or to inadequate fluid replacement.

Temperature Regulation

The thermal regulatory mechanism in premature infants is notoriously unstable, but the same is true of the full term infant and the postoperative newborn. Great care must be taken to monitor temperatures serially, either with esophageal or rectal thermistor probes, or with surface temperature sensors. Prolonged exposure in the air-conditioned operating room and the additional hazard of massive fluid replacement by cold blood or plasma add to this problem of temperature control. It is imperative that all solutions be warmed prior to administration if by no other means than

by coiling a plastic intravenous tubing in a container of warm water, the temperature of which should not exceed 110° F. Highly volatile prep solutions in the operating room should be avoided, and every infant should be placed on a circulating warm water blanket during the operative procedure. The controlled environment of the familiar isolette in the postoperative period is an ideal means of sustaining both warmth and humidity. Theoretically, the most accurate measure of infant temperature is achieved from surface temperature sensors, because the surface temperature loss is most directly related to caloric losses. However, the time-honored rectal thermometer is a very satisfactory monitor in the postoperative period.

Acid Base Balance

The importance of monitoring acid base balance is greatly increased during the following extensive surgical procedures such as, thoracic and cardiovascular operations. Metabolic acidosis is very commonly associated with rather short periods of inadequate cardiac output as a result of myocardial depression or with the use of certain open heart surgical techniques. The resulting metabolic acidosis is further increased with the infusion of stored blood that has a low pH. Administration of small quantities of sodium bicarbonate or, in more serious situations, some of the artificial buffering systems, such as Tris buffer, may be useful in the management of a serious imbalance.

Circulatory

Small bedside electrocardiographic monitors are especially helpful in the postoperative management of an ill infant. This is used primarily to record any significant changes in heart rate or rhythm, rather than as a means of studying myocardial electrical activity. After the more complex cardiac procedures an intra-arterial pressure recorder may be quite useful, especially if there is transient myocardial depression and peripheral vascular instability. Under these circumstances, careful monitoring of the intravascular pressure is a good index of cardiac output.

Respiratory

If short term respiratory support is necessary in the postoperative period, a plastic endotracheal tube may be used. For prolonged respiratory support and especially when respirators of a positive pressure type are necessary, we have been dissatisfied with prolonged tracheal intubation. With the introduction of a new solid Silastic tracheostomy tube which obviates the potential hazards of the metal tube in the infant's trachea, we are much happier about our results with the use of tracheostomies in infants. We have found the Silastic tracheostomy tube particularly useful when respirator support is necessary, as it completely frees the head and nasopharynx from intubation and makes for easier management and fewer complications of the upper airway.

Gastrointestinal

Following any extensive intra-abdominal operative procedure, a gastrostomy should be seriously considered as an important form of postoperative management. This is especially true in the newborn infant where prolonged nasogastric intubation is so frequently complicated by otitis media and upper airway obstruction. A simple Stamm type gastrostomy requires very little additional operative time and constitutes a superb means of immediate postoperative decompression of the gastrointestinal tract and an ideal way in which to begin early alimentation.

REFERENCES

1. Talbert, J. L., and Haller, J. A., Jr.: The Optimal Site for Central Venous Measurement in Newborn Infants. *J. Surg. Res.* **6**:168, 1966.
2. Talbert, J. L., and Haller, J. A., Jr.: Techniques of Central Venous Pressure Monitoring in Infants. *Amer. Surg.* **32**:767, 1966.

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on Thursday, March 20, 1969, and took the following actions:

1. Authorized preparation and dispatch of a letter to the members of the Baltimore City Medical Society in response to one mailed by the Baltimore City Medical Society President that was considered "inflammatory and erroneous."
2. Authorized expenditure of funds by the Traffic Safety Subcommittee for material dealing with legislative activity in connection with Implied Consent or Express Consent legislation.
3. Authorized expenditure of funds for expenses of two Delegates from The Johns Hopkins Medical School Student American Medical Association Chapter to attend the annual meeting of the national organization.

The Council met on Thursday, March 20, 1969, and took the following actions:

1. Authorized the Chairman to recommend to the House of Delegates the disbandment of the PL 89-97 Liaison Subcommittee appointed by the House in April 1966.
2. Voted to recommend to the House that Emeritus Membership be granted to various individuals on the recommendation of their component societies; and that honorary membership be granted to one individual on the recommendation of the Talbot County Medical Society.
3. Ratified legal defense for various physicians who were eligible; and denied the same defense to one physician who had not paid his dues before January 31 in the year in which the alleged offense occurred.
4. Heard that one case had been closed with a "modest settlement".
5. Heard various purposes for which Educational Funds had been expended throughout the state in hospitals; and referred to the Mediation Committee an amount on one hospital statement in order to ensure that a violation of medical ethics is not occurring.
6. Approved the 1972 Annual Meeting dates as April 5, 6, and 7.
7. Tabled until the June Council Meeting, the question of approval of a proposed Hearing and Vision Screening Program for preschool children.
8. Approved the recommendation of the Policy and Planning Committee that a photograph-portrait of all living past presidents be developed, as well as incoming presidents.
9. Adopted an addition to the Joint Statement on the Role of the Registered Nurse in the Care of the Patient with Cardiovascular Diseases in Coronary and Intensive Care Units as follows:

   "While standing orders may be established, it is essential that the orders applicable to each patient be included in that patient's chart and signed by the attending physician."

10. Declined to approve an addendum to the Physician Guidelines for the Performance of Therapeutic Abortions, which was recommended and reads as follows:

    "Continuation of a pregnancy in a fifteen-year-old or under may represent a grave impairment to the mental health of the mother and, therefore, warrants an evaluation for the possibility of a therapeutic abortion."

11. Adopted as policy that Committees and Subcommittees of the Faculty should not make direct approaches in any official capacity to General Assembly Representatives nor establish policy in connection with Faculty positions on legislation without prior clearance.

12. Declined to appropriate funds for testimonial scrolls to Nursing Associations complimenting them on the services provided to the public.
13. Authorized disposal of the large table in the library and its replacement with individual carrels, subject to approval and evaluation of the table's value by a qualified person.
14. Expressed its appreciation to the staff and Legislative Committee in connection with legislative activity during the 1969 General Assembly.
15. Asked the President to request a report from the Ad Hoc Committee on Tuberculosis Care, authorized by the Council at the January 1969 Council Meeting.

The Executive Committee met on April 3, 1969, and took the following actions:

1. Discussed with representatives of the Social Security Administration at Woodlawn the current Tuberculosis Screening Project in progress. The Faculty had some reservations about the wording of the letters being sent to the patient and his physician, as well as other aspects of the letters.

   It was agreed that the Faculty would make suggestions for improvements in these, and also, that Social Security Officials be encouraged to discuss these projects in advance so as to secure the cooperation of the individual physician and his organization. The Social Security Officials agreed to these suggestions.
2. Agreed to recommend to the Council's June 1969 meeting that the Faculty decline to approve of the proposed state-wide Glaucoma Screening Project as proposed by the State Health Department. This was recommended because prior approval has not been obtained by the organization providing the screening population.
3. Approved the proposal of the Maryland Tuberculosis Screening Project that would offer a Mantoux Method Test to all persons visiting the screening center who are over 15 years of age. Approval was based on the fact that advice and consultation would be provided physicians as to handling of positive reactors; and that all positives will be referred to the family physician, if the patient has one, or to the local health department. Positives will be adequately and systematically followed up.
4. Declined to provide a refund of 1969 dues to a member because such was not Faculty policy, since benefits had been received and no financial need was demonstrated.
5. Received information as to the list of items on permanent loan to the Carroll County Farm Museum from the Faculty through the Carroll County Medical Society. Adequate protection, insurance, and recognition of the Faculty will be provided.
6. Agreed to seek a formal meeting with the Governor to discuss the health problems facing the citizens of Maryland.
7. Heard a brief report on the proposed revised JCAH standards and authorized a letter to be sent to JCAH urging the requirement for Pathology Departments be changed to read:

   > "The hospital shall assure the availability of pathological facilities, etc."

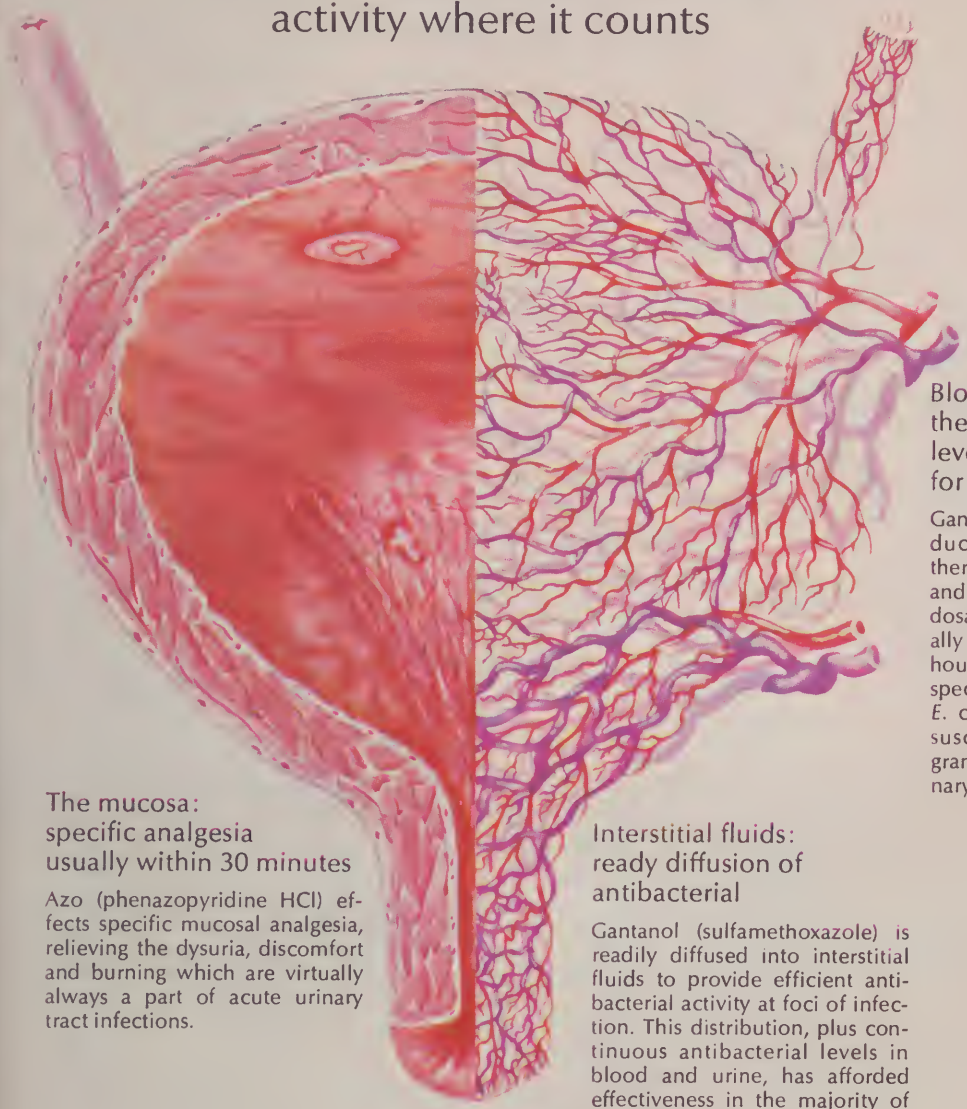
   rather than the proposed language which reads:

   > "The hospital shall maintain pathology facilities and services adequate to meet the needs of the patients."

   It also authorized publication of the report of the meeting in the JOURNAL to discuss these proposed standards. (The report will appear in the June issue.)
8. Selected an appointee to serve on the Advisory Committee on Foster Care of the State Department of Social Services.
9. Deferred taking action on proposed revised regulations regarding clinical laboratories.

Inner Sites...

In Cystitis...Azo Gantanol® focuses analgesic-antibacterial activity where it counts



The mucosa: specific analgesia usually within 30 minutes

Azo (phenazopyridine HCl) effects specific mucosal analgesia, relieving the dysuria, discomfort and burning which are virtually always a part of acute urinary tract infections.

Interstitial fluids: ready diffusion of antibacterial

Gantanol (sulfamethoxazole) is readily diffused into interstitial fluids to provide efficient antibacterial activity at foci of infection. This distribution, plus continuous antibacterial levels in blood and urine, has afforded effectiveness in the majority of infections in which it has been used.

Blood and urine: therapeutic antibacterial levels within 2 hours for up to 12 hours

Gantanol (sulfamethoxazole) produces prompt and prolonged therapeutic levels, in both blood and urine, with convenient *b.i.d.* dosage. Clinical response is usually obtained within 24 to 48 hours. The wide antibacterial spectrum of Gantanol includes *E. coli* and a variety of other susceptible gram-negative and gram-positive pathogens in urinary tract infections.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

ROCHE

Roche LABORATORIES

Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Preludin® phenmetrazine hydrochloride

Indications: Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.

Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

Under license from Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

She runs a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

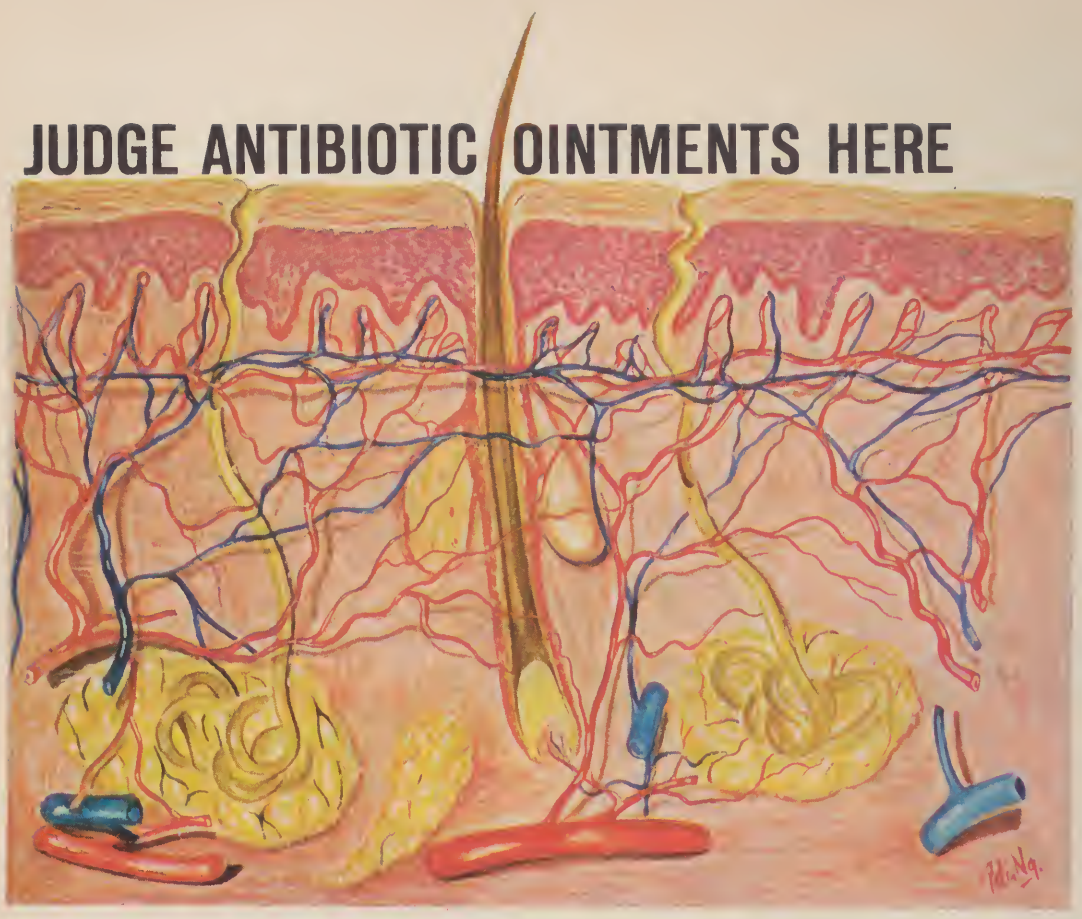
The Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride

Endurets® prolonged-action tablets

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City
health department

Public Health and the Conquest of Disease in Baltimore, 1792-1968

The Baltimore City Health Department, whose concern is the health of almost a million urban dwellers, is the oldest existing health department in the United States. Its beginnings go back to 1792 when Governor Thomas Sim Lee appointed two physicians, John Worthington, MD, and John Ross, MD, as health officers, to prevent the spread of yellow fever from Philadelphia to Baltimore. That their efforts may have contributed to the prevention of an outbreak is recorded in a report of 1793, the year the Health Department was officially established, which stated that Baltimore was "free from Yellow Fever." From this beginning, Baltimore's public health agency has waged a constant war against the threat of sickness and premature death to Baltimore's citizens.[1-3]

JOSEPH GORDON
Director, Bureau of Health Information
Baltimore City Health Department

The Early Years

During 1797, the year that saw the incorporation of Baltimore as a city, two major health ordinances were enacted—Ordinance 11, dealing with the prevention of pestilential and other diseases, and Ordinance 15, concerned with preventive sanitary measures.[4] These ordinances have served as bases for all subsequent hygiene legislation in the city. From the beginning, the Medical and Chirurgical Faculty of Maryland, the state medical society, founded in 1799,[5] and the Medical School of the University of Maryland, established in 1807,[6] have been closely identified with the development of community hygiene in Baltimore and with the City Health Department. As early as 1802, only four years after the publication of Jenner's famous work on vaccination for the prevention of smallpox, the Medical and Chirurgical Faculty sponsored vaccination, and in so doing, was the first medical society in the United States to lend its support to this important foundation stone of preventive medicine.[7]

For the record, it is interesting to point out that Baltimore's public health agency preceded the establishment of others in Philadelphia, New York city, and Boston. The first British health officer was appointed in 1847, 54 years after the appointment of Baltimore's.[8]

Presented at The XIIth International Congress of The History of Science, Paris, France, August 26-31, 1968.

During the greater part of the past century, until its last decade, the major focus of health department service was concentrated mainly on the sanitation of the environment, the abatement of nuisances, and the collection of vital statistics. These were supplemented by such attention to the prevention of the communicable diseases, by vaccination and quarantine, as the science of the day permitted.

The last decade of the nineteenth century was a significant period for both the practice of medicine and the administration of public health. In Baltimore, it witnessed the rapid acceptance of the germ theory of disease by the medical profession and by the educated public. In 1893, The Johns Hopkins Medical School was opened.[9]

Uniquely, Baltimore's pestilential diseases were conquered before the turn of the present century. By 1900, the mosquito borne diseases—malaria and yellow fever—posed little threat. Their control was the result of the elimination of breeding places through the gradual improvement of drainage in the city, and elimination of standing water in streets, gutters, alleys and in cellars—activities constituting major health department efforts.

Cholera was present in Baltimore periodically from 1832 to 1879. Its conquest can be attributed similarly to an upgrading of environmental conditions, the water supply, and the control of insects and the disposal of human wastes.

The maritime quarantine of the port of Baltimore was part of the City Health Department services from the earliest time, even before the incorporation of the city. A small hospital was made available in 1794 for cases of smallpox and cholera. The diseases were brought into port by means of vessels from foreign lands. This port quarantine service was transferred to the United States Public Health Service in 1918. Since that time, it has been under the jurisdiction of this branch of the Federal Government.[10]

Recent Developments

The first two decades of this century witnessed three fundamental improvements that contributed greatly to Baltimore's health. These were the establishment of a pure water supply, an adequate sewage disposal system, and the enactment of a milk control ordinance.

During the same period there developed an increasing interest in the supervision of the health of school children and in the control of mortality from tuberculosis. Other important health services which have been established since 1915 are the Bureau of Child Welfare, organized in 1919, now known as Child Health Services, and the Bureau of Public Health Nursing, established in 1920, after a gradual growth beginning with the appointment of one school nurse in 1905.

The twenties marked the beginning of the end of the common communicable diseases. With the support and cooperation of the medical profession, campaigns were successfully conducted against diphtheria, tetanus, whooping cough, polio and, more recently, measles. Smallpox has not been a threat since 1928 when the last case was reported in the city.

Dental health is being achieved through fluoridation of water supplies begun in 1962, and the provision of services through clinics to needy school children.

Child lead paint poisoning, caused by nibbling painted surfaces, is another disabling illness that is slowly disappearing. The year 1965 was the first year without a single death from this cause since 1931 when records were started. From 1931 to 1967 a total of 1,111 children have been made ill from lead paint poisoning, and 136 of them have died.

Air pollution, radiation hazards, and other environmental hazards—all of which contribute to the dangers of our ever-growing metropolitan populations—are in the process of being controlled.

Tuberculosis, a leading cause of death in Baltimore in the early part of this century and in the 1800's, is slowly but surely being defeated through intensive case-finding and treatment efforts and computerization control methods.

The new killers, heart disease, cancer and accidents will move to lower levels when citizens learn how to cope with the pressures of modern day living, and become alert to cancer's danger signals.

Inherent in preventing premature death from heart disease and lung cancer is understanding the real danger in smoking cigarettes.

The prevention of accidents, particularly on the highway, remains unanswered. Perhaps the solution lies in the area of driver education, motor vehicle design, and more stringent laws to keep the irresponsible driver off the highway.

Infant and maternal deaths are being attacked through a special Maternity and Infant Services Project. And the health betterment of our inner city children is being achieved through a Com-

prehensive Children and Youth Project. Both of these programs are being conducted with federal assistance from the U.S. Children's Bureau. Many of these developments were accomplished under the administration of Huntington Williams, MD, Director and Commissioner of Health from 1931 to 1962, and his successor, Robert E. Farber, MD.[11]

Leading Causes of Death

Most Baltimoreans today die of causes different from their predecessors of over 100 years ago. In the annual report of 1849 the leading cause of death was tuberculosis with 668 deaths; next was infant deaths of unknown causes with 618 baby victims while an additional 411 infants were stillborn and 290 died of cholera infantum. Other leading causes included: old age, croup, dysentery, scarlet fever, and typhus fever.[12]

Leading causes of death today are somewhat different. A total of 4,537 residents died of heart disease in 1967; 1,938 succumbed to the various cancer causes and 830 persons died of stroke or related cerebro-vascular disease. Other leading causes today include accidents, diseases of infancy, influenza and pneumonia. While the causes of death have changed, the average life expectancy for a baby born today in Baltimore or elsewhere in the United States is 70 years compared with 47 years in 1900.[13]

Population and Area

The population of Baltimore in 1790 was 13,500; in ten years it doubled to 26,514; in 1850 it was 169,085; in 1900 it was 509,000; today, Baltimore's population of 910,000, almost double that of 1900, places Baltimore among the top ten populous cities in the United States. The city area is 91.9 square miles of which 13.2 square miles is water.

Current Organization and Financing

The Department today consists of 844 budgeted positions and 175 part-time employees. The services are organized into five major sections as follows: Administration, Local Health Services, Maternal and Child Health Services, Medical Care Services, and Sanitary Services.

Within the Administrative Section are found the Bureau of Health Information, which utilizes the mass media, radio and TV; Vital Records; Biostatistics; and Special Home Services. Under Local Health Services are included the five Health Districts; Public Health Nursing; Dental Care; Communicable Disease Control including the Venereal Diseases and Tuberculosis; Mental Health; and an Alcoholism Center.

The Sanitary Section consists of the Bureau of Milk Control, Food Control, Environmental Health, Meat Inspection, and Industrial Hygiene which includes both locally and federally funded Air Quality Control Programs. Laboratory services are provided by the Maryland State Department of Health.

The appropriation for the fiscal year 1967-1968 for work to be performed by the Health Department was $13,371,159, of which the city's share was $3,472,269 and the remainder provided from federal, state and other sources.[14]

Looking Ahead

In view of current and projected Health Department programs the outlook for improved health records is most favorable. Plans are now underway to provide a further expansion of city services through the Mayor's decentralization of governmental services to the neighborhood level. In this the Health Department which has been on a neighborhood basis, almost since its inception,[15] stands ready to provide additional services where needed.

The future also holds promise for greater strides against communicable and chronic diseases and mental illness. New drugs, new therapies and new programs should ameliorate the problems of emotional illness, alcoholism and drug addiction.

As for our aging population—a start has been made to improve their health through medical and aid programs made possible by federal, state and local funds.

In this, and in other aspects of living, the continuing joint efforts of our public and private agencies—federal, state, and local—will make for better health not only for the residents of Baltimore, but for America and the world, for in the conquest of disease there is mutual cooperation between all nations.

But there is one last point that should be made clear—none of this will happen unless each assumes a personal responsibility for improving his own health and environment, and that of his neighbors and his community.

Public Health is individual health.

References will be supplied upon request



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

The National Scene

Expenditures in the United States in 1968 for the maintenance of state and county operated mental hospitals exceeded 1½ billion dollars.* This figure was larger than the total budget of Maryland, and all but a few of the most populous states. It reflected a record increase of 162 million dollars, or 11.5%, over the previous year's comparable figure. Total costs have nearly doubled since 1958, and are now almost 50% higher than they were five years ago.

Hospital expenditures have continued to go up, although the average number of patients in these facilities has decreased steadily. Nationally, a 24.4% decline in the patient population (from 546,337 to 412,818) occurred between 1958 and 1968. As a result, the average daily cost of caring for one patient rose from $4.04 to $10.47 during this ten-year period. Maryland, with a reported figure of $11.30, continued to rank approximately midway, between the high of $36.06 for Alaska and the low of $4.81 for Mississippi. Despite patent improvements, these figures indicate a widespread continuing lag behind comparable cost data for general hospitals, as well as for federal (V.A.) psychiatric hospitals.

FISCAL YEAR	*AVERAGE SIZE OF PATIENT POPULATION*	*NET LIVE RELEASES*	*TOTAL EXPENDITURES*	*EXPENDITURE PER NET RELEASE*
1958	546,337	161,884	$ 805,861,786	$4,978.02
1960	539,184	192,818	916,236,166	4,751.82
1962	519,742	230,158	1,033,567,884	4,490.68
1964	496,661	268,616	1,144,024,206	4,258.96
1966	460,910	308,636	1,300,380,295	4,213.31
1968	412,818	351,461	1,577,631,758	4,488.78
PERCENT CHANGE (1968 vs. 1958)	−24.4	+117.1	+95.8	−9.8

If present trends continue, the average daily cost per patient must be expected to rise 10% or more per year, even though the average total cost of each episode declines further. The only alternative to continuing, uninterrupted increases in state psychiatric hospital expenditures is to reduce drastically the size of patient populations by 1) providing community centered programs as an alternative to hospitalization, 2) further decreasing the average length of hospitalization, 3) transferring chronic, custodial patients to nursing home type facilities, and 4) developing and expanding aftercare services for released patients. These can be accomplished through closely coordinated and centrally directed programs offering a variety of community and hospital services to the mentally disturbed, and through the implementation of current and new concepts for the prevention of mental illnesses.

While these data reflect rising personnel-patient ratios, the current emphasis on psychopharmacology, and other innovations in treatment services, they are primarily related to the rapidly increasing patient turnover, resulting from shortened periods of hospitalization for new admissions and the transfer of many long term patients to nursing homes. As indicated in the above table, releases more than doubled between 1958 and 1968. In fact, this rise has been so large that the average expenditure required to produce one net release is now 9.8% less than it was ten years ago.

* Office of Biometrics, National Institute of Mental Health, Provisional Patient Movement And Administrative Data, State And County Mental Hospitals, United States, July 1, 1967-June 30, 1968.

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Measles Morbidity In Maryland

Below is a chart reflecting Measles Morbidity in Maryland during the period 1961 through 1968. The dramatic drop in measles cases is directly related to the widespread administration of measles vaccine which was begun in the latter part of 1966.

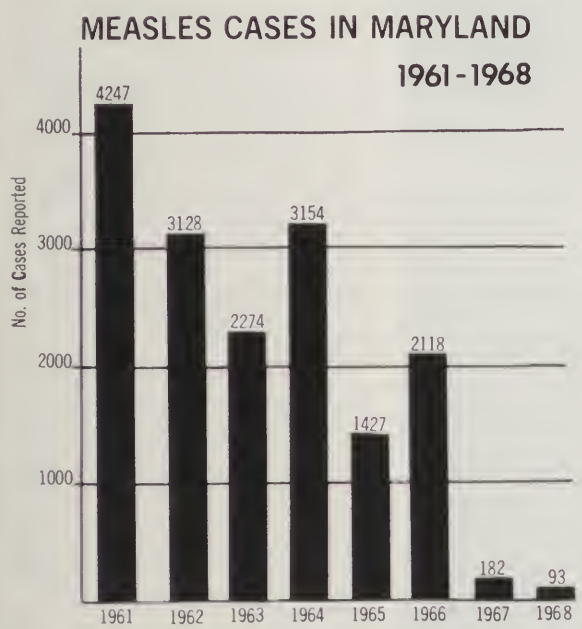


Chart prepared by the Division of Communicable Disease shows dramatic drop in measles cases.

Through mass measles vaccination campaigns on "Measles Sundays," in elementary school "mop-ups," and in health department clinics, over 215,000 children have been immunized since July 1, 1966. These efforts, along with the vaccinations given in private physicians' offices, have accomplished the near eradication of measles in Maryland.

Through the first eight weeks of 1969, five cases of measles have been reported and confirmed. This compares with 28 cases for the same period last year, and an expected 286 cases on the basis of the five-year median.

Although complete eradication may not be attainable, a continuing effort will have to be made to vaccinate all children and, thus, maintain a high level of immunity. So far, a good job has been done, but physicians cannot afford to slacken their efforts or they may have to do the job all over again. They should also be sure that all reported cases are true measles.

A flyer urging continuous efforts to control measles is being sent to physicians throughout the State in the very near future.

a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens... and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

Tetrex-F®
(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5—2/23/67. For complete information consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.
Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.
For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

Drugs and Driving

Gerard D. Dobrzycki, MD
Resident in Preventive Medicine
Maryland State Department of Health

From the Subcommittee on Traffic Safety of the Medical and Chirurgical Faculty of the State of Maryland

What are the basic requirements of a driver today? Dr. Ross A McFarland, Professor of Environmental Health and Safety at Harvard School of Public Health, lists the basics as, alertness and attention, judgment, coordination, perception of movement and distance, and ability to read signs.[1]



Before you take the wheel...

consult your doctor about

the side effects of any drugs you take.

Drugs either self-administered or prescribed by the physician can produce effects which can alter these basic requirements. The degree of effect covers the entire spectrum of impairment, depending on the severity of the drug reaction. Physicians must be alert to the fact that drugs, which are usually considered as having no side effects, can cause reactions in a few individuals which could markedly effect their driving ability. Keeping this thought in mind, it is obvious that the physician should not only concern himself with the effect of the prescribed medication on the patient's disease process, but also of its effect on the patient's normal daily activities.

The following is a resumé of a few of the more important groups of drugs that can cause untoward reactions which effect ones driving ability:

- Anti-Motion Sickness and Antihistamines:
  These frequently cause dizziness, drowsiness, and nervousness. Other less frequent effects are blurred vision, vertigo, restlessness, and a number of manifestations of their sedative action.
- Central Nervous System Depressants:
  Drugs such as morphine and meperidine, frequently cause dizziness, drowsiness, euphoria, and a decreased ability to concentrate.
- Central Nervous System Stimulants: Drugs such as the amphetamines mask fatigue, and may effect judgment. In large doses, one can experience headache, dizziness, agitation, irritability, and inability to concentrate.
- Hypnotics and Sedatives: These drugs not only cause drowsiness and sleep, but will synergize with ingested alcohol, and thus compound the side reaction.
- Tranquilizers: These can effect mental alertness, cause drowsiness, ataxia, and confusion. Paradoxical reactions such as excitement, stimulation, and acute rage, have been reported in some patients.
- Sulfonamides: Patients on this type of medication may experience headaches, nausea, dizziness, weakness, and poor coordination.

Since it is impossible to predict who will experience any untoward reaction, a few guidelines

for the physician when he is prescribing medication for his patient are listed:

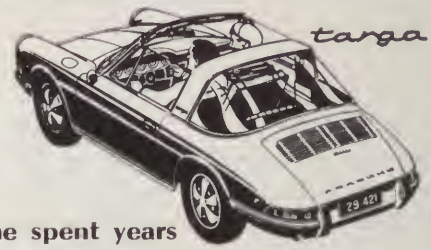
1. Could the medication being described affect the patient's physical ability?
2. Could the medication affect his mental ability?
3. Could the drug affect the patient's vision and hearing?
4. Could the drug affect the patient's judgment?
5. Could the medication affect his emotional makeup?

If the answer to any of the above questions is yes, then the patient should be adequately warned as to hazard involved in driving a vehicle.

REFERENCE

1. Rosenow, J. H., and Watkins, R. W.; The Physicians Role in Highway Safety. Reprint from *Modern Medicine* Vol. 25: 1967.

PORSCHE



Porsche spent years developing a great competition car so you could have fun driving to work.

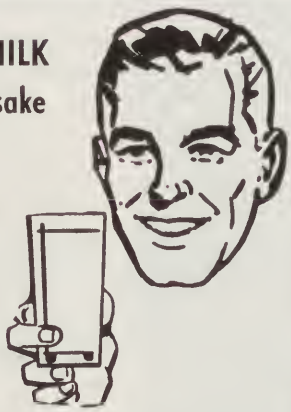


Both body styles available in four engines:
912 - 911T
911E - 911S

Sportomatic available on 911 series only

40 West VOLKSWAGEN
Phone: 744-2300
6624 Baltimore National Pike
West of Beltway Exit 15 on Rt. 40 West

DRINK MORE MILK
for your health sake



- More Vitamins
- More Minerals
- More Energy



Deliveries in Maryland, Washington, and Virginia.

Life Begins With Embassy Milk

EMBASSY DAIRY
DU 7-1441

1620 First St. N.W.
Washington, D. C.

ABBEY RENTS



SICKROOM EQUIPMENT

Prompt, professional service 24 hours a day, every day! A complete line of hospital beds, wheelchairs, traction equipment, oxygen, crutches, walkers, commodes, lamps, whirlpools—everything to help patients get well faster.

We Process MEDICARE Equipment Claims.

358-3400

6316 Reisterstown Road
Baltimore



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Various Pain Syndromes Which May Result from Osteoarthritis of the Cervical Spine

LEE H. RILEY, JR., MD
Associate Professor of Orthopaedic Surgery
Johns Hopkins University
School of Medicine

Arthritis Foundation Series
The Arthritis Foundation
(Maryland Chapter, 12 West 25th St., Balto., Md. 21218) is arranging a series of articles by experts on arthritis to appear from time to time in Rehabilitation Notes.

Osteoarthritis of the cervical spine may produce pain in several ways. Among the mechanisms which may be involved are:

1) Direct compression of neural tissue, either nerve roots or the spinal cord, associated with muscle weakness and objective sensory abnormalities following a dermatome distribution.[1-4]

2) Compression or irritation of the vertebral artery and the accompanying posterior cervical sympathetic plexus in their position on the posterior lateral aspect of the vertebral body by osteophytes originating either from the uncovertebral articulations (joints of Luschka), or from the facet joints. Symptoms resulting from transient insufficiency of the vertebral artery or from irritation of the accompanying sympathetic plexus can be vague, and are difficult to document, but may include headaches, tinnitis and vertigo, as described initially by Barre[5] in 1926, and more recently by Jung and Vierling[6] in the French literature, and by Sheehan, Bauer, and Meyer,[7] Chrisman and Gervais,[8] and Stewart[9] in the American literature.

3) Thoracic outlet compression of a major or minor degree resulting from increased tone in the scalene muscles, secondary to a primary abnormality within the cervical spine, with or without neural tissue compression. Many cases, designated as the so-called scalenus anticus syndrome, which are not associated with a cervical rib or a high thoracic scoliosis, may result from early degenerative cervical disc disease in an individual in whom the thoracic outlet was just adequate under ideal circumstances, but not adequate following the onset of degenerative change in the cervical spine with a resulting increase in tone of the scalene muscles. The neuro-physiological mechanisms which make such a concept permissible have been described by McCouch, Deering and Ling.[13] Pain resulting from brachial plexus compression is usually centered in the supraclavicular region and radiates into the arm and hand. It is generally increased by use of the arm, and relieved by rest. Occasionally, blanching of the hand is noted in association with pain if vascular compression is present. Tenderness is usually present over the brachial plexus, diminution or occlusion of the

radial pulse can be produced by the Adson maneuver, and neurological examination suggests compression of the brachial plexus.

4) Stimulation of the fine unmyelinated nerve fibrils with simple nerve endings which are found in the annulus fibrosis of the intervertebral discs, and also in joint capsules elsewhere resulting in stimuli which, on reaching the higher centers of the brain, are interpreted as representing pain or parathesias in the neck, in the lateral aspect of the arm, in the hand, in the tip of the shoulder, along the medial aspect of the scapula, or within the upper thoracic spine.[10-12] Evidence of direct compression of neural tissue such as, muscle weakness, reflex changes, and objective sensory changes are not noted unless, of course, neural tissue compression is also present.

In a given patient, one may see pain secondary to all four mechanisms. Separating them is at times impossible, in that symptoms of each overlap the other three, but an attempt to do so should be made whenever possible so that the primary lesion, whether it be an osteophyte producing neural tissue compression, a degenerative change involving an intervertebral disc, or a compromised thoracic outlet, may be diagnosed and properly treated.

By far the largest group of patients seen for evaluation of neck and upper extremity pain, resulting from osteoarthritis of the cervical spine, do not have evidence of significant brachial plexus compression, nor of vertebral artery irritation, nor of actual nerve root or spinal cord compression. The pain of which they complain is not radicular in nature, but rather dull, diffuse pain which may be felt in the base of the neck, along the vertebral aspect of the scapula, about the tip of the shoulder, the lateral aspect of the arms, or into the hands. Such pain may also be referred to the sub-occipital area of the skull and, on occasion, to the retro-orbital areas. These patients do not complain of hypothesia, but rather of painful parathesias in the arms and hands, which many describe as a "sandy" feeling. The mechanism of pain in this group of patients is irritation of the fine unmyelinated nerve fibrils which innervate the capsules of arthritic facet joints and the annulus fibrosis of arthritic intervertebral discs by motion of the involved intervertebral levels, as previously described.

Limitation of neck motion, production or intensification of pain by prolonged extension of the neck, pain on vertical compression of the cervical spine, and tenderness to palpation over the spinous processes of the cervical vertebra posteriorly, and over the intervertebral disc spaces anteriorly, are often noted on physical examination of these patients. None of these physical findings are truly objective determinations, but depend upon the patient's interpretation of maneuvers performed by the examining physician. If, however, the patient is not preconditioned as to the expected response, these tests have a high degree of reliability and when present, strongly suggest that symptomatic osteoarthritic changes are present within the cervical spine.

If the history and the physical examination strongly suggest such a diagnosis, and if disc space narrowing and bone spur formation are present at one or more levels within the cervical spine, the diagnosis may be made with a fair degree of certainty. On the other hand, if plain X-rays of the cervical spine do not reveal the bony changes suggestive of osteoarthritis. More sophisticated radiographic techniques may be indicated, such as, myelography, discography, and cinefluoroscopy.

Myelographic changes, frequently seen in the early stages of osteoarthritis of the cervical spine before disc space narrowing and spur formation are apparent, include posterior displacement of the dural sheath at the involved intervertebral level in the lateral view, and, in the AP view, central thinning of the dye column. These changes are the result of early fibro-chondro-osseous proliferation at the involved intervertebral disc space, and may precede the development of bone spurs by several years. It must be emphasized, however, that such findings would have no significance if the history and the physical examination did not strongly indicate the diagnosis.

Positive discography findings likewise will have no significance in an individual whose history and physical examination do not strongly suggest the diagnosis.

Cinefluoroscopy of the cervical spine will reveal limitation of motion, asynchrony of motion, or even subluxation at the abnormal intevertebral level. Again, as in the case of myelography and discography, such findings are of no significance unless the history and the physical examination strongly suggest the diagnosis of symptomatic cervical osteoarthritis.

In the absence of nerve root or spinal cord compression, surgery should not be considered initially in the treatment of osteoarthritis of the cervical spine. In most instances, mild analgesics

such as acetylsalicylic acid, and cervical traction used by the patient at home, when necessary, will be sufficient. But, it is important to remember that cervical traction must be properly applied. If it is not, and if the neck is maintained in an uncomfortable position (particularly in extension), symptoms will be increased rather than decreased by this technique. Pain of brachial plexus compression in the thoracic outlet is usually intensified rather than relieved by cervical traction; this point should be considered in the differential diagnosis. Less than ten pounds of cervical traction, applied with the neck in the most comfortable position, usually will temporarily relieve discomfort due to cervical osteoarthritis; it may be applied with the patient sitting or lying. The time spent in traction each day should correspond to the degree of discomfort experienced by the patient, and is best determined by him. That is, when neck pain subsides, traction is no longer necessary and the patient may relegate the home cervical traction unit to the closet until the next episode of pain, which may be days, weeks, or months later. Generally, at least 30 minutes of cervical traction two or three times a day is necessary, but much longer periods in traction may be necessary when acute pain and muscle spasm are present. A mild sedative and a muscle relaxant are useful in the treatment of acute attacks.

Anterior cervical fusion of the involved intervertebral levels is associated with a high degree of excellent results in those few patients who do not respond to conservative treatment. Surgical treatment should not be denied the rare individual who has not responded to conservative treatment, for prolonged pain is associated with a definite emotional response which may be more disabling than the pain itself. In a recent review of a group of my personal patients, surgically treated for unrelenting neck pain which had been present for an average of 31 months, the emotional response to long standing pain was what eventually disabled the patient, rather than the immediate disabling effects of the pain itself. As a group, they were depressed and irritable. Anxiety, despair, inability to concentrate, and agitation were prominent characteristics. Naturally, none of these are prone to generate a warm physician-patient relationship, unless the physician appreciates that they are the normal responses to long standing pain. The encouraging feature is that these characteristics disappeared following successful relief of pain. The patients returned to productive roles in society, the psychological improvement continued, and the patients were not disposed to seek surgery for other conditions.

REFERENCES

1. Semmes, R. E. and Murphy, F.: The syndrome of unilateral rupture of the sixth cervical intervetebral disc. *JAMA* **121:** 1209, 1942.
2. Spurling, R. G. and Scoville, W. B.: Lateral rupture of the cervical intervertebral discs. *Surg. Gyn., and Obst.,* **78:**350, 1944.
3. Mixter, W. J. and Ayer, J. B.: Herniation or rupture of the intervertebral disc into the spinal canal. *NEJM,* **213:**385, 1935.
4. Jefferson, M.: Laterally placed cervical discs. Review of twelve cases. *Lancet,* **1:**129, 1951.
5. Barre, J. A.: Sur un syndrome sympathetique cervicale posterieur, et sa cause troquent l'arthrite cervicale. *Rev. Neur.,* **33:**1246, 1926.
6. Jung, A. and Vierling, J.: Le syndrome de l'artere vertebrale au cours des arthroses cervicales et son traitement. Mem. Acad. Med. (Paris), **90/24:**687, 1964.
7. Sheenhan, S., Bauer, R. B., and Meyer, J. S.: Vertebral artery compression in cervical spondylosis. *Neurology,* **10:**968, 1960.
8. Chrisman, O. D. and Gervais, R. F.: Otologic manifestations of the cervical syndrome. *Clin. Ortho.,* **24:**34, 1962
9. Stewart, D. Y.: Current concepts of the "Barre Syndrome" or the posterior cervical sympathetic syndrome. *Clin. Ortho.* **24:**40, 1962.
10. Robinson, R. A., Walker, A. E., Ferlic, D. C. and Wiecking, D. K.: The results of anterior interbody fusion of the cervical spine. *J. Bone and Joint Surg.,* **44-A:**1569, 1962.
11. Robinson, R. A.: The problem of neck pain. *JAMA Alabama,* **33:**1, 1963.
12. Robinson, R. A., Riley, L. H., Jr., Johnson, K. A. and Walker A. E.: Unpublished data.
13. McCouch, G. P., Deering, I. D. and Ling, T. H.: Location of receptors for tonic neck reflexes. *J. Neurophysiology,* **14:** 191, 1951.

This is the new 144S Volvo Sedan For 1969



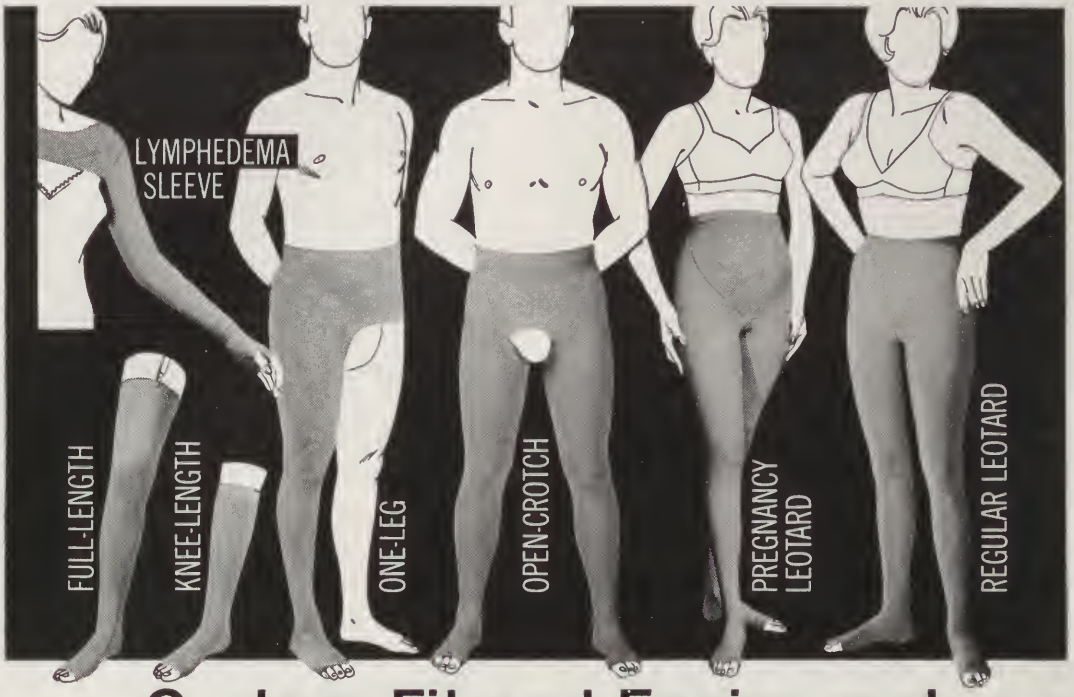
What a prescription for "Same-old-car-itis."

Volvo offers the most advanced safety features of any car. It's so economical it gets up to 25 m.p.g. With automatic transmission, stereo tape, air conditioning available—and world famous Volvo quality built-in, we think you'll agree the prognosis is extremely favorable.

FREE 24 HOUR DEMONSTRATION

michaelson motors, inc.

America's Largest Volvo Dealer
5801 REISTERSTOWN RD.
Open Nitely 'til 9:30 • 358-5800



Custom-Fit, and Engineered For Your Individual Patient

Jobst Venous Pressure Gradient® supports are custom-made and precisely fitted to the contour of the affected extremity of the individual patient in a series of careful measurements.

Even more *important* than the perfect fit, are the exact counterpressures built-in according to your own prescription!

Jobst Venous Pressure Gradient® elastic stockings are a treatment of *choice* for leg ulcers, varicose veins, stasis dermatitis, postmastectomy lymphedema, post-phlebitis syndrome, post-fracture, post-operative and injury edema.

For full information, have your secretary mail the coupon below. Or just call the number shown. You will find out why we named them "Service" Centers.

Jobst Service Center,

Suite 200, 818 Eighteenth Street, N.W.
Washington 20006, Phone (202) 298-5530

Suite 415, Medical Arts Bldg., 101 W. Read St.
Baltimore 21201, Phone (301) 539-0560



NAME _____

INSTITUTION _____

ADDRESS _____

CITY, STATE, ZIP _____



A Service of the Tuberculosis Association of Maryland

tuberculosis

RESIDUAL PULMONARY FINDINGS IN CLINICAL HYALINE-MEMBRANE DISEASE

Follow-up of 70 infants who had had hyaline-membrane disease at birth revealed that six had X-ray evidence of pulmonary fibrosis or overexpansion or both. These sequelae appear to result from the reparative process to the original insult to lung tissue.

Pulmonary sequelae are known to occur in infants who survive hyaline-membrane disease, but the frequency and origin of such sequelae are not known. The study reported was undertaken to examine the relation between certain aspects of the acute episode and the clinical forms, and long-term course of children surviving hyaline-membrane disease in infancy.

Between September 1961, and June 1965, 90 infants were discharged from the premature nursery of Vanderbilt University Hospital as having recovered from clinical hyaline-membrane disease. Adequate follow-up examinations and X-ray studies were available for two or more years on 70 of the children. The ratio of boys to girls was 2:1, which is typical of experience with hyaline-membrane disease.

Among the 70 children were 19 infants who had required prolonged ventilatory assistance in a respirator. The 51 infants who had not required such care were less severely ill than those who did.

During the follow-up period, 17 in the non-respirator group had pneumonia, bronchiolitis, or both. Two of the infants who had had respirator care had an unusual sequence of respiratory illnesses. Although mildly abnormal X-ray findings at follow-up did not appear to be related to clinical or biochemical values recorded during the period after birth, at least one X-ray film of each of six children had "moderate" over-all abnormalities. All had mild pulmonary fibrosis, and five had moderately extensive infiltrates at some time.

Hypoxia Severe

These six children had been severely ill and had required respiratory therapy for 34 to 116 hours. They had a tendency to more severe hypoxia than the other respirator-treated children, but the difference was not significant.

The two infants in the respirator group with the unusual sequence of illnesses had frequent severe episodes of pulmonary overexpansion associated with expiratory wheezing, rales, and rhonchi, for which they were hospitalized frequently during the first two years of life. There was no history of allergic disorders in the families of these children, and the wheezing and overexpansion did not respond to epinephrine as would have been expected of allergic bronchospasm. The findings of diffuse, patchy peribronchial and alveolar fibrosis suggest that this may represent an uncommon sequel to clinical hyaline-membrane disease.

In all six children the radiological abnormalities observed were increased parenchymal markings suggestive of pulmonary fibrosis, overex-

Frank M. Shepard, MD; Richard B. Johnston, Jr., MD; Eugene C. Klatte, MD; Henry Burko, MD; and Mildred Stahlman, MD. *The New England Journal of Medicine*, November 14, 1968.

panded lung fields, and infiltrates. These infants were among the 19 who had such severe hyaline-membrane disease that the use of prolonged negative-pressure ventilatory assistance was required for survival. The question is whether this residual pulmonary disease is an inevitable part of the recovery process from severe hyaline-membrane disease, or whether this is an iatrogenic disorder secondary to oxygen administration, respirator therapy, infection, poor pulmonary hygiene, or other possible factors.

Immaturity Not Responsible

Immaturity did not appear to be the sole cause of the radiological and clinical abnormalities noted at follow-up. There was no evidence of intrauterine bacterial pneumonia or extensive secondary bacterial pneumonia to suggest that superimposed infection at the time of the acute difficulty was a factor in the production of residual disease in these children.

In the management of severe clinical hyaline-membrane disease, it is common for the infants to be exposed for prolonged periods to high concentrations of oxygen to combat severe hypoxia. Oxygen toxicity has been suggested as the probable explanation for the severe process in infants so treated.

However, a careful study of infants dying with hyaline-membrane disease suggests a prenatal event that initiated pulmonary arteriolar constriction, leading to loss of nutritional blood supply to the lung. This is followed by necrosis, slough, and hyalinization of the bronchiolar and alveolar duct epithelium associated with an exudation of protein-containing fluid into damaged areas. A loss of pulmonary surfactant has been shown to be associated with these events, together with reduced compliance and the development of atelectasis. Vascular damage or a coagulapathy related to the initiating insult may account for the pulmonary hemorrhage occasionally seen.

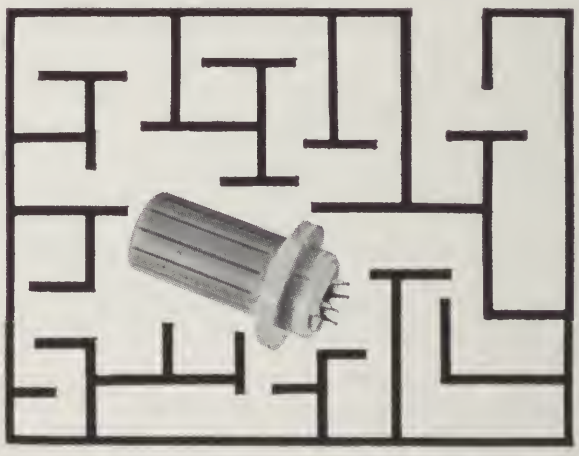
Reparative Process

In infants who survive extensive tissue injury, the subsequent reparative process could result in the peribronchial and alveolar fibrosis, such as was seen in the cases in this series and has been reported by others. Such lesions might possibly predispose the infant to respiratory infection and result in a fixed or progressive course of pulmonary fibrosis and overexpansion, with clinical and radiologic manifestations of chronic pulmonary disease.

On the basis of evidence so far reported, oxygen toxicity alone cannot be held responsible for the changes observed. Indeed, the prolonged exposure of the infants in this series to high oxygen concentrations was dictated by clinical and biochemical evidence of a degree of anoxemia that demanded correction for survival.

None of the infants in this series treated with negative-pressure respirators and high oxygen concentrations had late progression of pulmonary symptoms leading to death. In only two cases was positive-pressure ventilation also necessary for more than one hour. Arterial oxygen tension, carbon dioxide tension, and pH were repeatedly monitored throughout the course of the disease when more than 40% oxygen was used. Prolonged hypercapnia was never a serious problem in the post-respirator period.

There was no evidence that pulmonary infection due to gram-negative organisms, which often complicates prolonged endotracheal intubation, occurred, nor was there evidence of environmental inhalants such as silica dust as a cause of the persistent pulmonary disease.



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST

(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

473-9



JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Chronic Cor Pulmonale

Cor pulmonale may be defined as failure of the right ventricle, caused by abnormal physiologic function within the lung parenchyma or pulmonary vasculature. It is most commonly observed in patients with chronic bronchitis and emphysema; it is towards this group that the discussion will be directed.

DAVID G. SIMPSON, MD
Associate Professor and Head
Division for Pulmonary Diseases
University of Maryland School of Medicine

These diseases most often occur in combination, but the importance of bronchial obstruction in considering the etiology of cor pulmonale is demonstrated by the observation of right ventricular failure in patients who have chronic bronchitis without emphysema. Differentiation of the effects of bronchitis from those of emphysema is not difficult but demands a more sophisticated attitude than that which permits ready acceptance of the broad classification of "Chronic Obstructive Pulmonary Disease."[1]

Chronic bronchitis is defined as a chronic productive cough in patients who do not have another specific identifiable pulmonary or cardiac cause. In this disease, ventilation is decreased in the areas of the lungs obstructed by secretions. The perfusion of blood in these areas may be normal or almost normal so that the underventilation is out of proportion to the blood flow. This results in a decreased, arterial-blood-oxygen tension and, with more severe disease, an increased, arterial blood, carbon dioxide tension, producing respiratory acidosis in addition to the hypoxemia. The result is pulmonary arterial hypertension and, ultimately, right ventricular failure.

Patients in cor pulmonale most often have a combination of chronic bronchitis and emphysema. The diagnosis of chronic bronchitis, as noted, may be made from the history, but only in the moderate or severe forms can this be confirmed by physical examination: by the presence of wheezes, a prolonged expiration, rhonchi, or persistent rales over the lower one third of the lungs. The breathing sounds may be of poor quality if bronchial secretions have caused severe obstruction.

The definition of emphysema is based on pathological description: a state of overdistension of the lungs associated with loss of elasticity, with an essential feature, disruption of alveolar walls or "departitioning." With minimal involvement, em-

physema cannot be detected clinically. But when of significant severity, clinical and roentgenographic findings are reliable. An increased anteroposterior diameter of the thorax is more commonly the result of kyphosis than emphysema, and is more often observed in the short, squat, overweight patient with bronchitis, than in the elderly, underweight patient with emphysema. The manubrio sternal angle may, however, be abnormally prominent because of the overdistension and increased use of the accessory muscles of respiration. Additional evidence of overdistension of the lungs and fixation of the thoracic cage is seen in the decreased thoracic expansion, the decreased diaphragmatic excursion, and the increased resonance with some loss of cardiac and liver dullness. The breath sounds are diminished, and there is little increase with voluntary hyperventilation. Over the upper lobes, the breath sounds are louder than over the lower lobes—the result of the altered thoracic movements.

Examination of the chest roentgenogram allows confirmation of overdistension and disruption of lung parenchyma: the low flat diaphragm, best appreciated in the lateral and oblique views, the enlarged area of retrosternal translucency as observed in the lateral film, and attenuation of the peripheral vasculature. In the patient whose dysfunction results mainly from emphysema, the cardiac shadow is small and this is exaggerated by the low position of the diaphragm. But with a combination of diseases, severe enough to cause pulmonary arterial hypertension, there is first enlargement of the pulmonary outflow tract and later, enlargement of the transverse diameter of the heart, the right ventricular contribution to this being best appreciated in the right anterior oblique film.

Severe emphysema does not occur without some bronchitis, however insignificant. There is, therefore, no patient within this group to whom some help cannot be offered. The basic principle of treatment of cor pulmonale is the relief of hypoxemia. This may be effected by one of two methods: the provision of an increased alveolar oxygen tension, or improvement of the volume and distribution of ventilation.

A disposable mask, which applies the Venturi principle, permits the delivery of a 24% or 28% oxygen mixture from an oxygen tank, and provides a significant increase in alveolar and arterial-blood-oxygen tension without removing the hypoxic stimulus to respiration. Serial determinations of arterial-blood-gas tensions are essential.

The second method involves the use of a positive-pressure device. This may be successfully applied intermittently, if the condition of the patient allows and if medical, technical, and nursing personnel are available for constant care. If this is not feasible, ventilation must be assisted or controlled. With either method, the patient must be efficiently connected to a respirator. An endotracheal tube is preferable and may safely remain in place for 48 to 72 hours, after which a tracheostomy may be substituted if continuous ventilatory assistance or control is required. During assisted ventilation, the patient controls the pattern of breathing; during controlled ventilation, it is dictated by the ventilator, and appropriately adjusted to the needs of the patient. Adequate humidification of the inspired gas must be maintained, but the only additional aerosol which is useful is a topical bronchodilator, saline or water. The so-called detergents are of no value, and the only actions of the available mucolytic agents are to produce an unpleasant taste in the mouth and to interfere with the mechanical efficiency of the respirator.

Simultaneous correction of dehydration is important, even in the presence of the peripheral signs of congestive cardiac failure. The removal of secretions by efficient, safe, suctioning methods is then possible. The patient in respiratory failure is best treated in a Respiratory Care Unit.[2]

Other forms of treatment of cor pulmonale are less important. Digitalis is usually prescribed, but the need for this is considerably less than in the treatment of left ventricular failure. The importance of diuretic agents, too, has been overemphasized; the relief of hypoxemia usually results in a spontaneous diuresis, and diuretic agents too often cause abnormalities of electrolyte balance, particularly potassium. In the polycythemic patient, the need for phlebotomy is also secondary to the above measures. The hematocrit may be returned to normal or near normal levels by repeated removal of a small volume of blood (350 cc) over a period of several days. An antimicrobial agent, such as one of the tetracyclines or one of the synthetic penicillins, is often prescribed. But in the absence of roentgenographic evidence of pneumonia which, when present, is usually accompanied by pyrexia and a leucocytosis, the agent probably has little effect. Pneumonia is relatively uncommon, and the mechanical removal of secretions is

more important than attempts to eliminate "infection."

Obviously, these patients should not smoke. The stand-by of maintenance therapy is the effective application of a bronchodilator. Patients must be taught the following procedure: to exhale slowly to avoid air trapping, to synchronize the release of the aerosol with the beginning of inspiration, and to inhale deeply, and hold the breath for an instant, two or three times. This should be repeated three or four times daily.

The effects of chronic bronchitis and emphysema are established before patients become incapacitated. For most patients, the progression is a steady process of deterioration which may be predicted, but for some patients prediction of the future course is impossible.

REFERENCES

1. Filley, G. F.: Emphysema and Chronic Bronchitis: Clinical Manifestations and Their Physiologic Significance, *Med Cl N Amer* 51:283-292, 1967.
2. American Thoracic Society: Principles of Respiratory Care: A Statement by the Committee on Therapy, *Amer Rev Resp Dis* 95:327-337, 1967.
3. Burrows, B., and Earle, R. H.: Course and Prognosis of Chronic Obstructive Lung Disease: A Prospective Study of 200 Patients, *New Eng J Med* 280:397-404, 1969.

WOMEN OF ALL AGES

Train for a rewarding career as

MEDICAL ASSISTANT

- Short, comprehensive course in day or evening classes prepares you fully for this challenging and well-paid profession. Modern, air-conditioned classrooms with the finest equipment. Highly competent faculty. Free placement service for our graduates.

Approved by Maryland State Dept. of Education

DOCTORS....

OUR INTERNSHIP PROGRAM

offers you the services of a trained assistant for post graduate internship without salary obligation.
Call or write for full details.

MARYLAND ACADEMY OF MEDICAL & DENTAL ASSISTANTS

Executive Two Bldg. 32 West Road
Towson, Maryland 21204

Phone: 821-5222

SKIN PROBLEMS

Caused by itching due to:

Dry Eczema	Acne
Chafing	Ivy Poisoning
Minor Burns	Cold Sores
Athlete's Foot	Heat Rash
Dry Skin	Diaper Rash
Wind Burn	Chapping
Insect Stings	Hemorrhoids

For Safe, Sure, Speedy Relief —
— Get RESINOL GREASELESS!

Medical Scientists have conquered 6 dread diseases in the past decade, but they are largely in the dark, they admit, in finding relief for one age-old ailment—itching



New remedies containing antibiotics have been tested, but have often caused side effects which are worse than itching skin. After many years of research and testing, Resinol Greaseless Cream was developed. . . . A doctor's formula containing safe yet powerful ingredients, Resinol Greaseless contains an amazing, proven "anti-itch" medication called Resorcin, which quickly and effectively relieves most any kind of itching. Try Resinol Greaseless . . . You'll be delighted to find that it really works! At all drug stores. Buy a tube today.

Family First Aid in a Tube Carry in Purse or Pocket A Medicine Cabinet "Must"

"Resinol Really Works"

RESINOL CHEMICAL COMPANY
517 W. Lombard St.
Baltimore, Md. 21201

save time! save trouble! save money!

Forms & Stationery For Medical Offices Our Professional Service Division makes a specialty of stocking many forms for the profession.
It's so easy and economical to have all your stationery requirements taken care of by folks who understand your need for quality, accuracy and service.
We'll be happy to be your "Stationery Room," delivering your printing as you use it, promptly.
Let's get together – today!

EAGLE PRINTING COMPANY, INC.
1021 Cathedral Street
2 Minutes Away—at 752-5400

INSECTS . . . TERMITES . . . RODENTS

"Call the Rose Man" Phone: 467-5300

ROSE EXTERMINATOR CO.
"Call the Rose Man"
OVER 100 YEARS

3950 Falls Road, Baltimore, Md. 21211

F.H.A. INSPECTIONS — PRETREATMENTS

Prompt—Discreet—Efficient

S E R V I C E

★ This extended care Nursing Home is Approved by the Joint Commission on Accreditation of Hospitals
★ One story new fire-safe construction.
★ No steps, ramps or elevators needed.
★ Inspection invited. Reasonable rates.
★ All facilities available to private physicians.

Where your convalescent Elderly, Bedfast or Disabled

Enjoy being special

V. I. P.'s

(VERY IMPORTANT PARENTS)

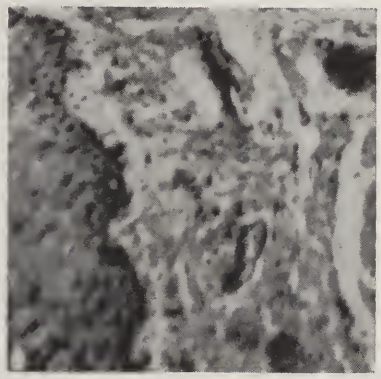


★ Professional Total Care Program
★ Continuous Physical Rehabilitation by registered therapists in specially equipped department.

PHONE VALLEY 8-6500

Dulaney Towson

NURSING & CONVALESCENT HOME
111 West Road, Towson
Off York Rd. Beltway Exit 26 South



JOHN E. ADAMS, MD, EDITOR

pathology

Federal Action Against Pooled Plasma

Another extraordinary chapter in the advance of federal regulation of the practice of medicine was written in March 1968 when the Committee on Plasma and Plasma Substitutes of the National Research Council, on patently insufficient grounds, categorically condemned the use of pooled plasma in medicine. The Division of Biologics Standards of the National Institutes of Health quickly enforced the pronouncement in May 1968 with the withdrawal of all plasma licenses.

The remarkable series of events occurred after a successful background of over 16 years of safe and efficacious use of plasma by a multitude of blood banks and clinicians. Numerous users, reporting their experiences with pooled plasma subjected to controlled temperature storage, have found that not only did its efficacy exceed that of whole blood transfusion in selected conditions of chronic plasma loss, but also that the safety factor exceeded that of whole blood transfusion.

In April 1968 a paper by Redeker, reporting the experience of commercially prepared pooled plasma use, appeared simultaneously with a statement of condemnation of pooled plasma by the National Research Council. This paper described a prospective study involving 120 patients who had bilirubin and enzyme determinations following plasma infusion and liver biopsy when elevations developed in these laboratory measurements. The control group was a series of 45 patients treated during the same period with albumin alone. The incidence of clinical and laboratory hepatitis was 10% in the plasma-treated group and 0% in the control group.

The gaps in this paper, used as prima facie evidence to outlaw pooled plasma for the nation, are as obvious as the preconceptions in the accompanying NRC statement. The paper admits that 50% of the cases were anicteric, proved by laboratory tests only. Deleting the anicteric cases still leaves an incidence of clinical hepatitis of 5%, which is in marked variance with all previously published work. The latter, cumulatively representing many thousands of cases, reported an experience of post-plasma hepatitis between 0% and 2%. Morbidity and mortality statistics were not presented. Liver biopsies were not described. There was no attempt to report the degree of severity of the hepatitis; it can be inferred from the description of the anicteric cases that most were quite mild.

The paper describes huge pools averaging 178 donors each, from commercial sources. This is in contradistinction to the work of others who used pools of 17 to 41 donors with a subsequent marked variance in the incidence of transmitted hepatitis. The concept presented in this paper, that the size of the pool bears no relationship to the incidence of hepatitis, is open to serious question. Further, there was no mention of any attempt (beyond NIH licensure) to inspect or control the plasma source. All are aware of the problems surrounding blood products from commercial sources.

The NRC Committee statement says that to refute findings cited in this study would require

additional data needing sizeable resources, effort, and time; and assumes that, therefore, the possibility that this work will be repeated is slight. They then acted rapidly to insure the sanctity of this work by outlawing the use of plasma, thus, effectively minimizing even more the possibility that the work would be repeated. Nevertheless, further work is needed since many unanswered questions remain. For example, it may be that the milder, anicteric cases of hepatitis are not infectious hepatitis at all, but rather antigen-antibody reactions resulting from a large amount of killed virus contained in large pools from paid donor sources. The only way to test this theory would be to attempt to transmit icteric hepatitis from anicteric recipients. The NRC ruling deletes consideration of such study *except* on an illegal or clandestine basis, the results of which could not be made public readily.

The study upon which the ruling was based was highly touted by the NRC Committee as a prospective, controlled one. Prospective it was, in that recipients of plasma were followed carefully after infusion. Controlled, it was not. No control of the source of plasma or the pool size was described or apparently exerted. This limited and unconfirmed study has equated all plasma with that used in this study. As a result, it has outlawed all of it, while completely ignoring far more extensive previous experience and the accumulated opposing evidence. When this study finds a 5% incidence of icteric hepatitis as opposed to the 0% to 2% incidence in extensive prior reports, something must be amiss.

Cogent arguments against the use of pooled plasma are available. Just as with the transfusion of whole blood, there is a small but distinct risk of transmitting hepatitis so that when albumin will serve equally well, it is used. However, equally strong arguments for the use of pooled plasma in selected conditions are available. To condemn the use of pooled plasma is to work to the detriment of the idea of component blood therapy—an integral part of modern medicine. There is significant economy to be gained from plasma, which is a natural by-product of blood bank operations. Although economy is not the total argument or even the major one, it is significant, especially now when the cost of medical care is rising, and when interest in controlling that cost is mandatory.

Such technocracy can be expected to continue unless something is done to curb it. The implications are numerous. An analogous situation, not exaggerated greatly, would be a dictum outlawing the use of anticoagulant therapy on the basis of a series of 50 cases of acute myocardial infarction treated with anticoagulant in which 25 died. These events deserve the thoughtful concern of all physicians. The argument is not so much in favor of the use of pooled plasma as it is against the unscientific and arbitrary method of judgment that condemned it, with which all who are interested in the welfare of medical practice should be concerned.

REFERENCES

1. Committee on Plasma & Plasma Substitutes of NRC: *Statement on Normal (Whole, Pooled) Human Plasma, Transfusion,* Vol. 8, March-April 1968, pp. 57-59.
2. Hoxworth, P. I.: *In Defense of Pooled Plasma,* bulletin, College of American Pathologists, Vol. 22, October 1968, pp. 333-339.
3. Hoxworth, P. I.; Haesler, W. E.; and Smith, H. Jr.: The Risk of Hepatitis From Whole Blood and Stored Plasma, *S G & O* **109**:38-42 (July) 1959.
4. Murray, Roderick, Memorandum: *Normal Human Plasma,* Division of Biologics Standards of NIH, May 20, 1968.
5. Redeker, A. G., et al: A Controlled Study of the Safety of Pooled Plasma Stored in the Liquid State at 30-32 C for Six Months, *Transfusion,* Vol. 8, March-April 1968, pp. 60-64.



8521 LOCH RAVEN BOULEVARD
BALTIMORE, MARYLAND
668-2300

Our experienced counseling assures complete and practical funeral service with concern for individual needs and desires.

JOHNSON
Funeral Home



WILLIAM E. JOHNSON

How to get Paid for Treating Military Patients

Payment to civilian sources for emergency professional services rendered to military personnel, who are on active duty (as contrasted to retired, or inactive members of the National Guard or Reserve), is the responsibility of the surgeon of the geographical area in which such services are provided. Collection cannot be made from the Office for the Civilian Health and Medical Program for the Uniformed Services (OCHAMP-US), Denver, Colo., or its fiscal agents, who are responsible only for the payment of medical care rendered to authorized dependents and retired military personnel.

When a patient is identified as an Army member, on active duty, notification should be made immediately by telephone to the appropriate Army headquarters, as listed below, reporting where the individual is and the nature of the treatment required. The cost of the telephone call will be reimbursed with the other charges.

The Army headquarters will advise the caller about the administrative management of the patient, and how to submit the bills for service.

HEADQUARTERS FIRST U.S. ARMY

Commanding General
First United States Army
ATTN: Surgeon
Fort George G. Meade, Md. 20755

Telephone Number:
Area Code 301

Weekdays: 677-2566 or 677-3616
Nights, weekends and holidays:
677-4805 or 677-4826

GEOGRAPHICAL AREA

Connecticut
Delaware
Kentucky
Maine
*Maryland
Massachusetts
New Hampshire
New Jersey
New York
Ohio
Pennsylvania
Rhode Island
Vermont
*Virginia
West Virginia

HEADQUARTERS THIRD U.S. ARMY

Commanding General
Third United States Army
ATTN: Surgeon
Fort McPherson, Ga. 30330

Telephone Number:
Area Code 404

Weekdays: 752-2816 or 752-2425
Nights, weekends and holidays:
752-3606 or 752-3705

Alabama
Florida
Georgia
Mississippi
North Carolina
South Carolina
Tennessee

* Less certain counties. See Military District of Washington on next page.

HEADQUARTERS FOURTH U.S. ARMY Commanding General Fourth United States Army ATTN: Surgeon Fort Sam Houston, Tex. 78234 *Telephone Number:* Area Code 512 Weekdays: 221-4323 or 221-2013 Nights, weekends and holidays: 221-2745	*GEOGRAPHICAL AREA* Arkansas Louisiana New Mexico Oklahoma Texas
HEADQUARTERS FIFTH U.S. ARMY Commanding General Fifth United States Army ATTN: Surgeon Fort Sheridan, Ill. 60037 *Telephone Number:* Area Code 312 Weekdays: 926-3275 Nights, weekends and holidays: 926-2238	Colorado Illinois Indiana Iowa Kansas Michigan Minnesota Missouri Nebraska North Dakota South Dakota Wisconsin Wyoming
HEADQUARTERS SIXTH U.S. ARMY Commanding General Sixth United States Army ATTN: Surgeon Presidio of San Francisco, Calif. 94129 *Telephone Number:* Area Code 415 Weekdays: 561-3945 or 561-4287 Nights, weekends and holidays: 561-2497 or 561-2780	Arizona California Idaho Montana Nevada Oregon Utah Washington
HEADQUARTERS MILITARY DISTRICT *OF WASHINGTON* Commanding General Military District of Washington Building T-B, 2d & R Streets S.W. Washington, D.C. 20024 *Telephone Number:* Area Code 202 Weekdays: 695-7615 Nights, weekends and holidays: 697-3722	District of Columbia City of Alexandria, Va. Maryland Counties: Calvert Charles Montgomery Prince Georges St. Marys Virginia Counties: Arlington Fairfax King Georges Prince William Stafford Westmoreland

BLOOD PLAN

of the

METROPOLITAN WASHINGTON BLOOD BANKS, INC.

Not For Profit

A BLOOD DONATION TODAY PROTECTS YOU AND YOUR FAMILY TOMORROW

- A Medically Supervised Blood Benefit Program
- Individual—Family—Group Memberships

T. A. Loosbrock, Exec. Dir.

915 19th St. N.W., Suite 500 Phone 737-0060
Washington, D.C. 20006

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery **MU 5-3232**

D. Stuart Webb

Advertising Services, Inc.

306 N. Gay Street Baltimore, Md. 21202

STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

We Repair and make Lamps

"Lamps make the home Beautiful"

LE 9-0222 403 N. Charles Street
Baltimore, Md. 21201

ALCAZAR SWIMMING POOL

Cathedral & Madison Sts.
Baltimore, Maryland

Phone: 837-8400

Heated Pool *Steam Room*

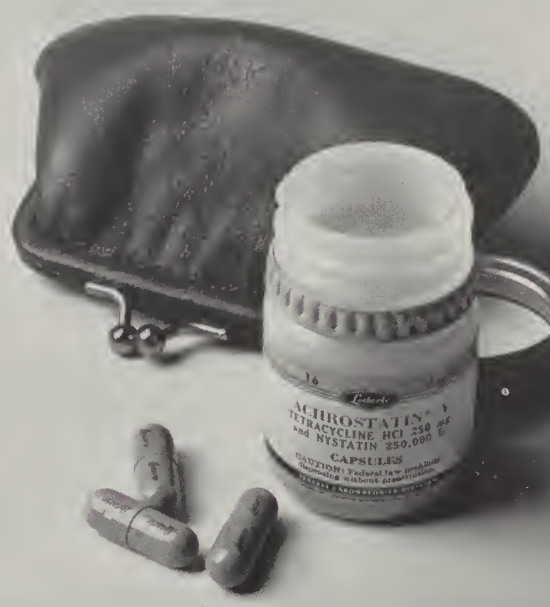
Our POOL and STEAM ROOM are available to patients who would like to exercise themselves back to Good Health!

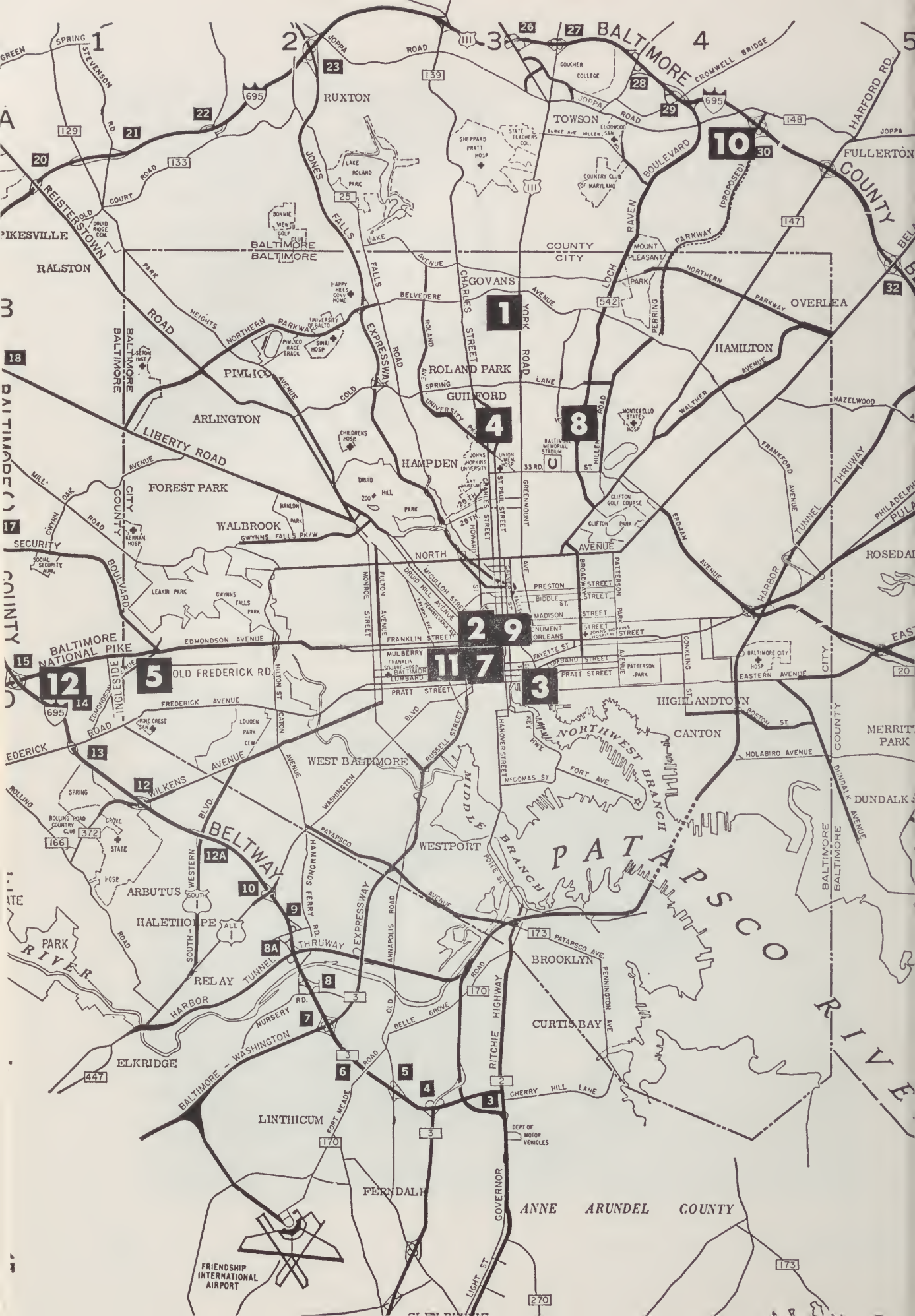
Open Mon. thru Fri. *10 A.M. to 3 P.M.*
September thru May

Rates: $15.00 Yearly Membership

Call: Mr. D'Agostino

—The lowest priced tetracycline—nystatin combination available—




BALTIMORE
COUNTY
ANNE ARUNDEL COUNTY
PATAPSCO RIVER
NORTHWEST BRANCH
MIDDLE BRANCH
PATAPSCO
RUXTON
TOWSON
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
ARLINGTON
PIMLICO
FOREST PARK
WALBROOK
SECURITY
RALSTON
PIKESVILLE
OVERLEA
HAMILTON
FULLERTON
NORTH
PRESTON
BIDDLE ST.
MADISON
FRANKLIN STREET
MULBERRY
LOMBARD
PRATT STREET
EDMONDSON AVENUE
FREDERICK AVENUE
WEST BALTIMORE
WESTPORT
HIGHLANDTOWN
CANTON
BROOKLYN
CURTIS BAY
ELKRIDGE
LINTHICUM
FERNDALE
ARBUTUS
HALETHORPE
RELAY
BELTWAY
FRIENDSHIP INTERNATIONAL AIRPORT
DEPT OF MOTOR VEHICLES
BALTIMORE NATIONAL PIKE
OLD FREDERICK RD.
BALTIMORE - WASHINGTON
CHERRY HILL LANE
PATAPSCO AVE.
HOLABIRD AVENUE
DUNDALK
MERRITT PARK
ROSEDALE
EASTERN AVENUE
BALTIMORE CITY HOSP.
PATTERSON PARK
CLIFTON PARK
CLIFTON GOLF COURSE
MONTEBELLO STATE HOSP.
BALTIMORE MEMORIAL STADIUM
JOHNS HOPKINS UNIVERSITY
UNIVERSITY OF BALTO
SINAI HOSP
CHILDRENS HOSP
SHEPPARD PRATT HOSP
STATE TEACHERS COL.
GOUCHER COLLEGE
COUNTRY CLUB OF MARYLAND
LAKE ROLAND PARK
DRUID HILL PARK
DRUID ZOO
GWYNNS FALLS PARK
LEAKIN PARK
LOUDEN PARK CEM
PINE CREST SAN.
SOCIAL SECURITY ADM.
KERNAN HOSP.
HANLON PARK
BONNIE VIEW GOLF CLUB
DRUID RIDGE CEM.
ROLLING ROAD COUNTRY CLUB
MOUNT PLEASANT PARK
CLIFTON PARK
JONES FALLS EXPRESSWAY
CHARLES STREET
YORK ROAD
LOCH RAVEN BOULEVARD (PROPOSED)
HARFORD RD.
CROMWELL BRIDGE
JOPPA ROAD
COLD SPRING LANE
UNIVERSITY PKWY
NORTHERN PARKWAY
LIBERTY ROAD
PIMLICO AVENUE
FREDERICK ROAD
WILKENS AVENUE
HILTON ST.
MONUMENT ST.
PATTERSON PARK AVENUE
FRANKFORD AVENUE
HARBOR TUNNEL THRUWAY
BALTIMORE BELTWAY
ANNAPOLIS ROAD
OLD BELLE GROVE ROAD
RITCHIE HIGHWAY
GOVERNOR
FORT MEADE
PENNINGTON AVE.
LIGHT ST.
WASHINGTON BLVD.
RUSSELL STREET
MONROE STREET
FULTON AVENUE
EATON ST.
HANOVER STREET
HAMMONDS FERRY RD.
SOUTH-WESTERN
SOUTH-EASTERN
GREENMOUNT AVENUE
ST PAUL STREET
33RD ST.
39TH ST.
28TH ST.
HOWARD STREET
LIBERTY HEIGHTS AVENUE
WALTHER AVENUE
HAZELWOOD AVENUE
FROMAN AVENUE
CONKLING ST.
BOSTON ST.
EASTERN AVENUE
PERRING PARKWAY
MILLER ST.
MCCOMAS ST.
FORT AVE.
POTEE ST.
PATAPSCO AVENUE
BALTIMORE BELTWAY
BALTIMORE BELTWAY
BALTIMORE BELTWAY

Restaurants of Distinction

Locations indicated by numbers on map

Miller Bros.

"The Place to Eat"

NATIONALLY FAMOUS

THE SHOW . . . Just across the street
Mechanic's Theatre in the new Statler
Hotel. Open for luncheon, dinner, and
heatre suppers . . . until midnite.
il Lounge (with piano bar) open 'til 2 A.M.

reservations call **752-4822**

3

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

Baltimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center

Open 12 noon to 3 A.M.—Closed Mondays

For Reservations Call **685-2811**

2 blocks south of the Flag House

300 ALBEMARLE STREET

4

Broadview Restaurant

Cocktails • Dinners • Luncheons

Private Entertaining Facilities

116 W. University Parkway at 39th St.

CALL CH 3-1216

MILTON INN

Circa 1740

ne Amid Early American Charm
Warm, Gracious and Inviting

elected By Life & Time Magazines
as One of America's Finest Inns

Lounge & Dining Room Available
for Private Parties

ATTILIO ALLORI, Owner

i. North of Cockeysville on York Rd.

RKS 771-4366

11

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*



Your Host
Tom d'Anna

539-9021

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

Dobbs House

Breakfast-Luncheon-Dinner
anquets-Meeting-Private Parties
We Cater Wedding Receptions

ated in Quality Court Motel—West
U.S. Route 40 & Beltway Exit 15
801 Baltimore National Pike

744-1510

5



Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS

Finest Sea Foods
Prime Meats

5653 Old Frederick Road

East of Ingleside Ave., off Baltimore National Pike

TED KUCHTA, *Manager*

Phone 744-0223

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE

Baltimore 1, Md. MU 5-6790

CARRY-OUT SERVICE

SPECIAL LUNCHEON and DINNERS

PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.

Sunday 12 Noon to 3 A.M.



SPECIAL AT THE

BULOUS CLUB VENUS

Evening for Two . . Only **$15**

er good every night except Saturday

Make Reservations Now

g Plaza Shopping Center—Beltway Exit 30

Reservations Call **NO 8-2232**

9

Cork 'n Bottle Restaurant

STEAK — SEAFOOD — PRIME RIB

COCKTAILS

LUNCHEON — DINNER

Major Credit Cards Honored

Private Party Rooms

22 E. FAYETTE ST. BALTIMORE, MD.

½ Block from Charles Center

539-1268

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD

Cocktails Mexican Beers

Tuesday thru Sunday

Open 5:00 P.M.---12:00 P.M.

Dinner and Snacks

Closed Monday

Phone 435-9858

For elderly patients
in need of a mild tranquilizer
consider **Tybatran®**
brand of tybamate

(When you consult
the Prescribing Information
you may agree
it makes good sense)



PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.

Miss Gladys Deeds
Manager

213 West Saratoga St. 727-7011



BOLTON HILL *Dinner Theatre*

"SEPARATE ROOMS"
May 6 — June 1

"ONCE MORE WITH FEELING"
June 3 — June 29

Dinner Theatre—7 P.M.
Dancing 11 P.M. - 2 A.M.

FREE VALET PARKING

CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
11.30 AM - 2 AM
DINNER SERVED
5 PM - 10 PM

for Reservations
call 728-0800

Luncheon Served 11:30 AM-2 PM
Luncheon Fashion Show Every Thursday
Baltimores Only Professional Dinner Theatre



Apply internally.

Take a relaxing break for Coca-Cola. Couple of times a day. Because Coke has the taste you never get tired of. It's always refreshing.

The Maryland Council of Coca-Cola Bottlers

Rising Mental Health Demands, Innovative Programs and Budgetary Appropriations

George McK. Phillips, MD, FAPA
Superintendent
Crownsville State Hospital
Crownsville, Maryland

The average daily admission rate at Crownsville State Hospital has increased 54% over the past three years. This increase has been accompanied by an increase in releases of 101% during the same period, with a net decrease in the daily average inpatient population of over two hundred. Likewise, the budget has been increased 34.5%, most of which has been absorbed in meeting salary increases and rising operating costs.

This reduction in the daily average census is being accomplished by continuously building a positive mental health attitude towards the patients and towards mental illness itself, rather than by indiscriminate or inappropriate releases. Classification and prognostication of patients by diagnosis are being de-emphasized, except to meet medico-legal standards and broad treatment objectives, while intensive educational programs, aimed at the reorientation of all levels of the staff, are being stressed.

The hospital strives to reserve 24-hour inpatient hospitalization for protection of the patient and his family or the community, and when it is the only alternative for meeting specific therapeutic and rehabilitation requirements. As a result, a large number of persons, formerly kept in the hospital in custodial care 24 hours a day, now live in the community. Some are followed in day and evening care centers, and others in the hospital and other mental health outpatient clinics.

At the same time, consultants in family therapy and group psychotherapy visit the hospital one day a week, and conduct teaching conferences and workshops involving multi-disciplinary personnel at various levels of the administrative tree, in a simple, but effective, approach to reaching the hospital's objectives.

A pilot project, in which interested personnel and volunteers are trained as co-therapists and co-therapy aides in multiple family therapy, has been implemented and successfully operating for the past eighteen months. Psychiatric aides are also being trained to visit relatives and to work with families at home, as well as in the mental health clinics under supervision of professional personnel.

Staff previously confined to in-hospital assignments, working closely with county mental health clinic personnel, are taking on responsibilities for those community mental health programs which emphasize prompt, intensive and accurate evaluation of mental dysfunctions and the day to day living situations with which they may be associated. Existing personnel and facilities are utilized for providing evaluation, treatment, and rehabilitation services in the community. This orientation to providing mental health services has received little attention in past years—to some degree because of lack of funding, but mainly because of archiac attitudes towards the mentally ill, and rigid personnel role assignment.

Even if funds were available, a painful reality is that there is just not enough additional personnel with appropriate community orientation and expertise to meet the challenge of, and total demands for, mental health programs at the present salary levels. Change and expansion of roles of existing staff appear to be the most immediate avenue of optimism.

These changes are sometimes referred to as "innovative" at Crownsville. They are, in fact, a wider and more effective utilization of available personnel and facilities.

The hospital is constantly seeking ways to ef-

ficiently expand the role of existing personnel. As this continues, more personnel—professional and non-professional—are reoriented to thinking and acting "community" through appropriate educational programs. They are taking on those assignments in the community, germane to effective patient care in rehabilitation, in keeping with their change in orientation and increase in ability. Local and regional communities are also being oriented to thinking "self-sufficiency" through public education efforts, in order to create a receptive atmosphere for the "converted" hospital employee.

At the State level, it would be advantageous now to study in depth those hospitals which appear to be gaining the most mileage with what they have—not merely in terms of daily average inpatient census, but also, and perhaps primarily, in terms of admission and release rates, as well as extent and effectiveness of innovative projects. This evaluation should include existing hospital staff participation in providing mental health services in the community to the residents of its catchment area. Innovative programs of proven value should be supported and pushed across the board.

Funding should not be disallowed merely because of the decline in daily average inpatient population. The yardstick for changes in budgetary appropriations should be more appropriately based on the number of persons served and the treatment services offered; as well as the relative costs to the taxpayer for the various innovative approaches to providing needed mental health services. Should these factors not be considered, those community and other innovative mental health programs, which have a direct effect on inpatient population decline, would necessarily have to be curtailed. Unnecessary, inappropriate, and lengthy hospitalization would ensue and the hospital would be back where it started several years ago—a bulging, overcrowded and inefficient custodial human warehouse.

Visit the #1 Spot for Your Diet Needs
Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)
For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic
SPECIAL DIET SHOP
Phone SA 7-0383

TOURS ARRANGED TO MEDICAL CONFERENCES AND CONCLAVES
Domestic and International
GLOBETROTTER TRAVEL
A Professional Travel Service
BALTIMORE: REISTERSTOWN ROAD PLAZA • 358-6444
BALTIMORE: MONDAWMIN SHOPPING CENTER • 669-8200
WASHINGTON: WHEATON PL. SHOPPING CTR. • 949-1700

Why take chances.
Why not let CHERNOCK guard your valuable key records in their modern, safe, fireproof warehouse.
Surprisingly inexpensive.
CHERNOCK
MOVING & STORAGE
PHONE 685-7630

Help for the Alcoholic:
HIDDEN BROOK
Understanding care in an atmosphere conducive to Recovery

Request Brochure. Call 734-7554
Thomas Run Rd. Belair, Md. 21014

Tyson Street Open House to Benefit Eye Bank

More than a dozen colorful homes and attractive gardens of residents of the 800 and 900 blocks of Tyson Street, in downtown Baltimore, will be open to the public as features of the 19th Annual Tyson Street Open House on Saturday, June 7, as a special benefit project for the Medical Eye Bank of Maryland.

The Tyson Street community pioneered the restoration of Baltimore mid-city townhouses in 1946. It has been nationally recognized as a model area of the nation, and is one of the Baltimore landmarks illustrated in the current issue of Encyclopedia Britannica.

Many of the homes were built prior to 1800. They are believed to have been constructed as either slave quarters, or housing for laborers on the Bolton Estate which was northwest of Baltimore, when the town was incorporated in 1797. While the buildings have been enlarged and modified over the last century and a half, the area served as home for different classes of people over the years.

Just a century ago, Tyson Street was recognized as one of Baltimore's worst slum areas. It had formerly been known as one of the city's "bootlegger's rows," and at one time, the small houses were priced low enough to be purchased by former slaves with "freedom money."

In 1946, Edward Rosenfeld, who had already earned an international reputation as a creative artist, purchased a corner house for $3,000 to convert it into a studio and home. Within three years, the remaining 18 houses of the 900 block of Tyson Street, between Read Street and Park Avenue, had been purchased by persons who wanted to create a community of mid-city residences.

Over the past two decades many additions and modifications have been made to the homes, and today Tyson Street is the home address of attorneys, educators, librarians, doctors and representatives of other professions and skills.

Each year since 1950 the residents of Tyson Street have opened their homes to the public for general inspection, and a glimpse at some of the most colorful small gardens in Baltimore.

The influence of the 900 block Tyson Street has spread to the 800 block, and to nearby shops and residences in Baltimore's traditional "antique row." For a contribution of $2 per person to the Medical Eye Bank, more than a dozen homes and shops will be on view. All events will take place between 10:00 A.M. and 5:00 P.M., and funds will be used to further the research and service activities of the world's largest organization securing eyes for cornea transplantation, and ocular research purposes. For tickets and detailed information, please contact the Medical Eye Bank of Maryland, 22 W. Franklin Street, Baltimore, Maryland 21201, or phone 539-4353.



SKILL SURGICAL, INC.

SUPPLIES & EQUIPMENT
for
PHYSICIANS–SURGEONS
HOSPITALS

5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

A & F Nurses Registry



LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

Registered & Licensed

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.
BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

Offering 2 GENERATIONS of research and experience in cooperation with the MEDICAL PROFESSION

CORRECT SHOES

for every Rx need

Normal	Pronators
Straight	Supinators
Corrective	D. B. Splints

Modifications and Custom Work

HERBERT COX

HU 4-0021
1433 Reisterstown Rd.
Pikesville 21208

SA 7-7883
210 N. Liberty St.
Baltimore 21201

- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE
EVANGELICAL PRESS

THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

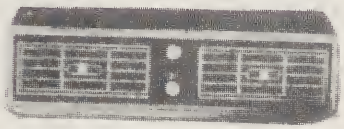
DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

JOIN OUR TAPE CLUB
FREE! FREE!
One tape Free with every 10 tapes you buy at our everyday low prices. **25% DISCOUNT** on all tapes, by such artists as: **Beatles, Glen Campbell, Cream, Frank Sinatra, Al Martino, Dean Martin.**

20TH CENTURY AUTO RADIO & TV
912-922 CATHEDRAL ST. (at Eager)
BALTIMORE, MD. 21201
Phone 539-0662

20TH CENTURY
DRIVE-IN—FAST SERVICE



STEREO TAPE PLAYER
for CAR, BOAT or HOME

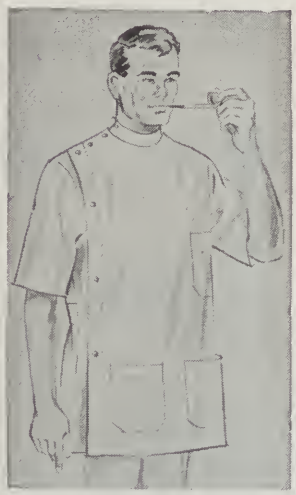


AUTO AIR CONDITIONERS
SALES and SERVICES

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222

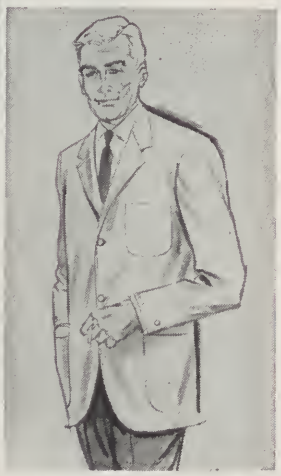


Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab
Sizes 34 to 46
White **$10.99**
Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**
#400—100% Cotton—2x1 Sanforized Poplin **$4.99**
#800—100% Nylon Taffeta **$5.99**
#805—100% Dacron Shantung **$6.99**
All men's jackets short sleeves only
Sizes 34 to 46

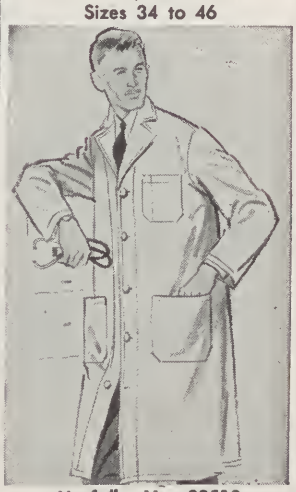




MEN'S LAB
511—8 oz. Sanf. Duck **$5.99**
5514—Tan. Sanf. Linene **$5.99**
414—Heavy Sanf. Twill **$6.99**
811—100% Dacron Herringbone Twill **$12.99**
Sizes 34-46
WOMAN'S LAB
310—Sanforized Twill Jean **$5.99**
3310—65/35 Dacro-Gab. **$9.99**
Sizes 28-40

- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**
#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**
#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**
Sizes 34 to 46



OTHER STORES IN

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639

NOW
A NEW CONCEPT
in
BOOKEEPING
and
TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

FEDERATED BUSINESS SERVICES, INC.

Box 580
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager

AMA Surveys

Physicians engaged in the group practice of medicine comprised 10.9% of all doctors involved in patient-care activities in 1965, according to a recent statistical study made by the AMA's Department of Survey Research.

"Group medical practice," as defined by the AMA Council on Medical Service, "is the application of medical services by three or more *full-time* physicians formally organized to provide medical care, consultation, diagnosis, and treatment through the joint use of equipment and personnel, and with the income from medical practice distributed in accordance with new methods previously determined by members of the group."

The survey views the group practice of medicine as "a significant force in the health care system."

Of the 4,289 medical groups responding to the AMA survey, 2,161 (50.4%) were single-specialty groups; 651 (15.2%), general practice groups, and 1,477 (34.4%), multi-specialty groups.

The group physician complement numbered



PLANNING, ENGINEERING, INSTALLATION & SERVICE
We Feature **AMPEX**
VIDEOTAPE RECORDING EQUIPMENT
Call Today for a Free Demonstration

high fidelity house

6307 YORK ROAD *(Drumcastle)* **BALTIMORE, MD.**
Phone **323-3713**

Group Practice

28,381, of whom 25,452 were on a full-time basis.

The survey reported 88 groups utilizing a prepayment mechanism as part of, or all of, the group activity. "Most of the prepaid groups (88.6%) were multi-specialty groups, and almost all of the physicians in prepaid groups (98.5%) were in multi-specialty groups," according to the survey.

Physicians affiliated with prepaid group practices numbered 3,491, 71.1% of whom were in the general specialties.

"Of the 31 (35.2%) prepaid groups which reported an affiliation, nine were associated with hospitals, only one with a medical school, and six were associated with a labor union, employee association, or consumer cooperative. The remaining 15 prepaid groups reported affiliation with 'other' organizations. No prepaid group reported an affiliation with industry."

Three of the 29 states, where prepaid group practices were found, contained 44.3% of the prepaid groups, and 71.7% of the physicians. The three states were California, Minnesota, and New York.

HOOD CONVALESCENT HOME

"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF

CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED

National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM

Certificate Holder—Baltimore County
Fire Prevention Bureau Award

LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800

5313 EDMONDSON AVE.

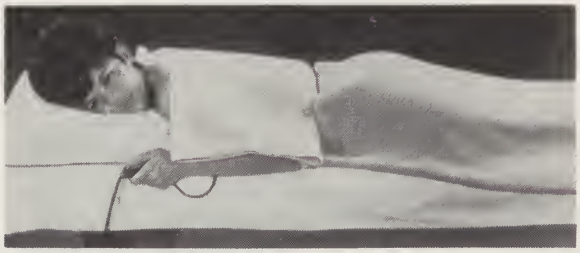
M.D.'s or DENTISTS in ASSOCIATED PRACTICE

Up to 8,000 sq. ft. of office space, custom-finished to your specifications. Prime northwest Baltimore location. 2 min. from Sinai Hospital, Jones Falls Expwy. Ample parking space. Jitney service to nearby bus stops. Special tax advantages for resident doctors. Leasing and Management, Chas. H. Steffey, Inc. Call 685-2412 or 542-6684

GREENBERRY WOODS

NORTHERN PARKWAY AT JONES FALLS EXPRESSWAY

Now When You Recommend Moist Heat,



Recommend Automatic Moist Heat.

Until now, application of moist heat required boiling water, hot towels, and somebody to apply them. The Battle Creek THERMOPHORE changes all that. It provides instant and automatic moist heat, intensely hot, deeply penetrating.
The patient simply plugs it into an outlet. This unique hot fomentation pad then generates its own moisture from the air. Intensely hot moist heat is constantly maintained, and evenly distributed throughout the pad. No water is needed, no filling or emptying is required.
Large 13" x 27" pad covers back, or chest and abdomen, or both legs. Safety thermostat turns it off automatically, prevents overheating.
Price is **$35.00.** Also available in medium size 13 x 13 **$25.00.**

Phone for Free Descriptive Literature, or See It At . .

THERAPEUTIC APPLIANCES, INC.
JULES MORSTEIN
1114 Light St. **Phone 752-6996**
Baltimore, Md. 21230

Mercedes-Benz does not make conventional cars... and never will!

TOWSON VALLEY MOTORS
Mercedes-Benz
103 E. Pennsylvania Ave., Towson (Just behind Hutzler's) 821-8000

BERNHARDT L. PIELKE CLARA S. LANDSCAPE SERVICES



Give your home new beauty with
SKILLFUL LANDSCAPING
TREES, PLANTS, SHRUBBERY
expertly planned and planted
FREE ESTIMATES
BELTWAY GARDEN CENTER
7937 Belair Road, Baltimore Md. 21236 **NO 8-3965**

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ **INGLESIDE SHOPPING CENTER**
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ **HILLENDALE SHOPPING CENTER**
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

PROFESSIONAL LEASING
Special low rates for our medical customers. Call or stop in.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL
5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

Physicians Questioned on Heart Transplants

The majority (55%) of physicians questioned in a Playback Poll by Marion Laboratories said that they would *not* consent to a heart transplant on themselves even if they had advanced heart disease with a poor prognosis.

Only 27% of the respondents indicated that they would consent to such transplant surgery, while 18% were undecided.

Playback posed this same question to the physician panel. At that time less than a majority of respondents (42%) said they would not consent to transplant surgery, while 36% said that they would say yes. Six months and more than 20 transplants later, the appeal of such surgery to the Playback physician appeared to be lessening.

Among cardiologists, 17% said they would consent to transplantation now (27% said yes six months prior), while 63% said they would not consent (53% said no when previously questioned).

The statistics revealed that positive opinion toward transplant surgery is directly related to the age of the doctor. Physicians under 35 years voted 35% in favor of transplant, 44% against; in the 35-50 age bracket, opinion was 26% in favor, 54% against; in the 50-64 category, opinion was 25% in favor, 58% against.

The most significant switch in opinion during the six-month period was in the group of doctors over 65. Earlier 36% would have accepted a transplant, six months later only 24% would. When first questioned, 49% would not have accepted a transplant, later 71% said no. Earlier 15% were undecided, but later the undecided comprised 2% of the respondents.

Some of the physicians' reasons for not accepting such surgery included:

"Rejection will be 100%"

"It is not a practical solution. At present it is surgical exhibitionism"

"Not at this time. Results too poor."

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

F.T.D.

Geo. RADEBAUGH *& Sons*

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And free your secretary to be your secretary again.

professional systems and services *division of*

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3886



Multiphasic Screening

The value of a periodic health examination has long been stressed. Now, more than ever before, persons in presumably good health are encouraged to have an annual "check up." But a thorough examination, including X-rays and laboratory tests, is time consuming and costly. For the medical profession, the improvement of health care for all people is a constant challenge, yet the limitations of time, money, and manpower are always present.

A plan to cope with these conditions is the development of multiphasic screening programs. These may be described as automated multi-test laboratories where test procedures, which include X-rays, electrocardiograms, visual and hearing acuity tests, blood pressure readings, glucose tolerance, complete blood testing and medical questionnaires, are administered. The data from all tests is recorded on punch cards and fed into a computer which produces a report on each individual. The purpose of screening is to sort apparently "well" persons into two groups.

1. Those having abnormalities indicating the characteristics of a certain disease.
2. Those not possessing abnormalities outside the pale of normal health.

The computerized health protection center is not a substitute for periodic physical examination or any other traditional health care. The tests are designed to be evaluative, and are intended to alert the physician to areas requiring diagnostic attention.

The United States Public Health Service now has four demonstration projects for multiphasic screening, three of which are operative and one under development. The objectives of the PHS centers are, "The development of a model, high-quality health maintenance system for a defined urban population, using automated equipment, and techniques for screening, and incorporating the principles of health counseling, referral and follow-up to insure subsequent physical examination by the participant's own physician. The ultimate goal is to decrease mortality and morbidity through early disease detection and intervention."

The four PHS centers are located in Milwaukee, New Orleans, Brooklyn, and Providence, Rhode Island (opened in January 1969). At the Brookdale Center in Brooklyn, the most populated of the four areas, they hope to screen 10-15,000 people in the first year.

The precedent for these multi-test centers comes from the Kaiser Foundation Hospital in Oakland, California which began its screening program in December 1966. There is also a private screening center in Southfield, Michigan and, through the Regional Medical Programs, Missouri, Tennessee, and the Rochester, New York area are launching large-scale screening programs.

Though services in the PHS centers are free to patients, the cost of screening is now $40 per person with $25 per person as a goal in all centers. This is compared with $85 per person charged by the Michigan center or $200, if similar tests were ordered by a private physician.

Dr. Morris F. Collen, Chief of Staff at the Kaiser Foundation Hospital has suggested that the automated lab can operate most efficiently as part of a medical center with inpatient and outpatient services. He suggests that hospitals in communities of 100,000 or more will be affiliated with an automated laboratory for admission, preoperative, and periodic health examinations. The labs will probably be connected with a regional computer center providing data processing by telephone lines.

Dr. Frederick C. Swartz, in a statement to the U.S. Subcommittee on Health of the Elderly in September, 1966, and the AMA Council on Medical Services, in their report (D. A-68), presented both benefits and limitations of the concept of multiphasic screening. They found that the plan would provide economic health appraisal to large numbers of the adult population who might not otherwise receive health care. It would also relieve the acute medical manpower shortage by conserving physicians' time. On the other hand, it may create depersonalization of health care, and false security or unnecessary anxiety by issuing a report to a patient without adequate physician follow-up.

The PHS and the AMA both acknowledge that

study and analysis of the automated multi-test system are imperative. Controlled trials should be given in many settings where continuous evaluation and revision of tests, for suitability to the population, would take place. More accurate data is needed to determine what constitutes "normal" conditions, and there is a need to study the long range possibilities for disease prevention, not just detection. The real impact of multiphasic screening on medical manpower and cost conservation must be studied carefully. Moreover, successful incorporation into the community health service structure and cooperation by local physicians to insure follow-up consultation whether reports are negative or positive is essential.

The AMA report calls multiphasic screening a promising technique. Dr. Swartz believes it to be a major field of medicine of the future and a major challenge of today. It could well provide an answer for the patient who asks, "How well am I?", "Could I run a block?", "Could I run a mile?", "Could I handle a job with added responsibilities and pressures?".

Al-Lin Ambulance Service

"AT THE BELTWAY"

4811 E. LEEDS AVE. BALTIMORE, MD. 21227

24 Hour Emergency Ambulance and Oxygen Service

Trained and Experienced Personnel

2 Way Radio Controlled

247-2111

MERCEDES-BENZ

Baltimore's only Authorized Dealer for Sales, Service and Parts

R. & H. Motors, Inc.

4810 Belair Rd. 426-9200

Baltimore, Md. 21206

BALTIMORE OXYGEN SUPPLY CO., INC.

OHIO CHEMICAL DISTRIBUTORS

Therapy and Medical Gases

Oxygen Tents

Resuscitators and Apparatus

PHONES: 789-8100 727-4748

Main Office and Plant

LINTHICUM, MARYLAND 21090

MANUEL SCHWARTZ

HEARING REHABILITATION

321 Medical Arts Bldg. Phone: 685-4898

BALTIMORE, MARYLAND 21201

DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION

Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

COLOSTOMY
ILEOSTOMY

Appliances and Disposable Bags

CALL

FIELDS PHARMACY

IN PIKESVILLE

for convalescent supplies and service

FOR RAPID DELIVERY 486-3300



Patio — Garden — Terrace Shops — Nursery
Indoor-Outdoor designs — Landscaping
Casual furniture Gifts for all occasions.

Valley Mart

6241 FALLS ROAD

VA 5-2500

Transplants Discussed at First Renal Seminar

"Physicians should be concerned with prolonging personality rather than just a biochemical system," stated Dr. Alfred B. Starratt, rector of Emmanuel Episcopal Church, at a seminar on the moral, legal, and medical aspects of organ transplants and kidney dialysis held at the University of Maryland School of Medicine.

The seminar was the first of eight on renal disease that are being held this year at the medical school. They are being sponsored by the Maryland Kidney Foundation and arranged by Glenn Lubash, MD, associate professor and head of the division of renal diseases and hypertension.

"As more is learned about a disease," Dr. Starratt said, "the more responsibility a doctor has to tell his patient the prognosis and diagnosis of his illness. No one wants to live as a vegetable."

The other participants were David Thompson, MD, professor at Cornell Medical School and director of the New York Hospital, and John F. King, legal advisor to the Maryland Medical and Chirurgical Faculty, and a member of the Governor's Joint Commission on Organ Transplantation. Samuel T. R. Revell, MD, professor of medicine, moderated.

Dr. Thompson raised the question of where the huge sums of money needed to save the lives of kidney patients will come from. He said that the majority of patients are treated by dialysis, although more transplants are being performed, and that the costs for care may rise to $500 million a year. He believes that federal funds may be the answer, and that ideally, the regional medical programs could set up facilities.

Mr. King discussed the Maryland Anatomical Gifts Law, passed in May 1968, which authorizes physicians to make transplants from cadavers and live donors. He said that Maryland's law is one of the first and may become a model for other states.



WHEN YOUR PATIENTS NEED NURSING CARE

Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED

24 HOUR SERVICE ESTABLISHED 1935

BALTIMORE, MARYLAND 21229

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS

AND LOAN ASSOCIATION

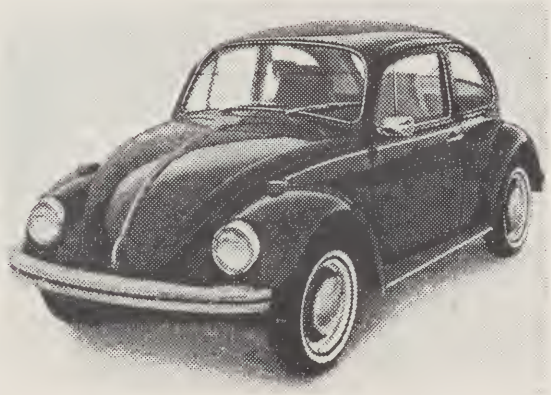
INCORPORATED 1907

421 NORTH CHARLES STREET

CORNER FRANKLIN STREET

BALTIMORE, MARYLAND 21201

PHONE 752-6000



Live below your means

If you'd like to get around the high cost of living, we have a suggestion.

Cut down on the high cost of getting around. And buy a Volkswagen. It's only **$1799***

* Suggested retail price east coast P.O.E. Local taxes and other dealer delivery charges, if any, additional.

MARYLAND VOLKSWAGEN

1212 E. 25th St.

(corner of Harford Rd.)

BALTIMORE, MD. Phone 889-7616

SHIRL ANN MOTEL
and Apartments

2 Olive Avenue . . . at the Boardwalk
REHOBOTH BEACH, DEL.

Sundeck Overlooking Ocean
Apartments Available by Week
Sleeping 4 or 5 People
Air Conditioning Available

Phone 227-7169

MAE HALL McCABE
REALTOR

Service since 1937

Our complete sales and rental service
is always at your disposal for

- COTTAGES
- APARTMENTS
- SUMMER HOMES

Call . . . AREA CODE 302-227-2558

or write . . . 38 Rehoboth Avenue
Rehoboth Beach, Delaware

The BIG One On The Ocean
Ocean City, Md.
Stowaway
MOTEL
21st to 22nd St. & BOARDWALK



"The Stowaway Has Everything"

- One full block of beautiful beach
- Air Conditioning • Free Parking
- 120 Units, 33 Efficiencies
- Children's Pool • Color TV Room
- Magnificent Olympic-size Pool
- Restaurant and Cocktail Lounge
- Free TV in every room • Supervised Beach
- European Cuisine

For Reservations—Call ATlantic 9-6191

DIPLOMAT MOTOR HOTEL



Largest, Most Luxurious Units on the Beach

Bedroom and Efficiency Units

Continental Cuisine

Food prepared by our chef for the most discriminating connoisseur

100% Air Conditioned

- Swimming Pool
- Dining Room
- Cocktail Lounge
- Coffee Shop
- Two Double Beds in Each Unit
- Wall-to-Wall Carpeting
- Private Balcony Porches and Private Entrances
- TV and Telephone in all Units
- Ceramic Tiled Baths

We Cater To Conventions

Accommodations for small groups and up to 300 persons

"THE PRESTIGE MOTEL"

DIPLOMAT
MOTOR HOTEL

Boardwalk at 26th St.
Telephone 289-7148

OCEAN CITY
MARYLAND

OPEN DAILY THROUGH LABOR DAY!

Breakfast—Luncheon—Dinner

Credit Cards Honored

AT THE NATION'S SUMMER CAPITAL . . .



2 Christian St., Rehoboth Beach Delaware

Phone Area Code: 302-227-2561

Blanche Thompson at the Electric Organ

VISIT OUR UNIQUE GIFT SHOP

HARRISON HALL



Finest Resort Hotel in Maryland

117 OCEAN COOLED ROOMS

Open through September

CONVENTION FACILITIES ELEVATOR SERVICE
OCEAN DINING ROOM EUROPEAN PLAN
PRIVATE BATH IN EVERY ROOM
GOLF PRIVILEGES • COCKTAILS • FREE PARKING
NEW OLYMPIC SIZED SWIMMING POOL

Mrs. G. Hale Harrison, Manager-Owner

BOARDWALK AT 15TH ST. OCEAN CITY, MD.

Phone AT 9-6222

STUART KINGSTON GALLERIES



THE ROYAL SHAH KERMAN CARPET

Finest in all the world

Exclusively at Stuart Kingston Galleries

AUCTION SALES NIGHTLY – 8 P.M.

The First Gallery in the First State

Exhibition hours – 10 A.M. – 4 P.M.

Phone (302) 227-2524

On the Boardwalk—REHOBOTH BEACH, DEL.



For the Best in Leisure Living

Enjoy a vacation at the

Atlantic Sands MOTEL

Boardwalk and Baltimore Ave.

REHOBOTH BEACH, DELAWARE

- 80 FINE ROOMS
- AIR CONDITIONED
- TELEVISION
- BEACH SHOP
- HEATED POOL
- TELEPHONE SERVICE
- RESTAURANT
- ELEVATOR SERVICE

OPEN ALL YEAR LONG!

Write for Reservations . . . . . or

Phone **(302) 227-2511**

Resort Advertisers in This Issue

Easton

Walsh and Benson 138

Ocean City

Beach Plaza Hotel/Bo-Con Apartments .. 138

Diplomat Motel 136

Harrison Hall 137

Stowaway Motel 136

Rehoboth Beach

Atlantic Sands Motel 137

Dinner Bell Inn and Motel 137

Mae Hall McCabe 136

Shirl Ann Motel and Apartments 136

Stewart Kingston Galleries 137

Watch Future Issues for

Where to Go

Who to See

and

What to Do

on the Maryland/Delaware Eastern Shore

BEACH PLAZA HOTEL
BO-CON APARTMENTS
and Efficiencies

Fully Air-Conditioned and Heated



Dining Room, Coffee Shop & Bar

- 200 feet on Ocean Front with Guarded Beach
- Free Off-Street Parking
- TV and Telephone in Every Room and Apartment
- Telephone on Beach
- Delicious Food and Soft Music in our Air-Conditioned Dining Room
- Golf Privileges
- Color TV in Lounge



BOARDWALK AT 13th ST., OCEAN CITY, MD.
Phone: 289-9121



"Peach Orchard Point"
BEAUTIFUL WATERFRONT ESTATE

Beautifully located on the Miles River, just 5 miles west of Easton, this charming 7-acre estate has a spacious residence of Colonial Brick, with 4 bedrooms, 3 tile baths, living room with fireplace, "living kitchen" with attached den & fireplace, large screened porch overlooking "Peach Orchard Cove." Entire waterfront bulkheaded; 75 ft. pile driven wharf; protected anchorage adequate for most any vessel.

EXCLUSIVE AGENTS

Walsh & Benson, Inc.
REALTORS
301 – 822-1415
EASTON, TALBOT COUNTY, MD.

Schools teach your kids how to read and write.

We teach them how to save lives.



help us help

The American Red Cross.
We don't know where
we'll be needed next.

You don't either.

advertising contributed for the public good

ADVERTISING COUNCIL

First Millionaire

The term "millionaire" did not come into existence until 1843 at the death of Pierre Lorillard, who had become immensely wealthy manufacturing cigars and snuff. Writing the obituary, a newspaper man minted this phrase and it became part of the language. *(the late Kentucky Irish American)*

Baltimore's most unusual dining place!

Famous
Owl Room



Belvedere Hotel
Charles & Chase Streets

FOOD AND DRUG ADMINISTRATION

Bureau of Medicine

IS SEEKING

- **PHYSICIANS**—Board certified or Board eligible in various specialties.
- **The Board of Medicine,** one of the major divisions of FDA, is responsible for developing medical policy on the efficacy and safety of drugs, medical devices, and substances used in foods, drugs, cosmetics, and hazardous household products. The individual physician is assigned to one of four major subdivisions of the Bureau and reviews and evaluates scientific and clinical data relating to safety and efficacy of drugs, medical devices, and substances.
- **Starting salary $19,771** with assured periodic increases; excellent fringe benefits; professional development programs; equal opportunity; U.S. citizenship required. (The proposed pay increase would raise the starting salary to approximately $21,600 in July 1969 if approved.)
- **Located in Arlington, Virginia** in modern office-apartment-shopping complex.
- Major relocation expenses reimbursed.
- Submit brief resume or for complete information submit inquiry to:

BUREAU OF MEDICINE
Code A-16 P.O. Box 2000
Eads Station, Arlington, Virginia 22202

Classified

POSITIONS AVAILABLE

PHYSICIAN FOR INDUSTRIAL CLINIC—July 1, 1996 or sooner. Excel. opp. Starting salary $22,000. Profit-sharing plan after 1st yr. Partnership if desired. Contact: Maxwell Hurston, MD, 919 18th St., NW, Washington, D.C. 20006.

GP PARTNERSHIP—Percentage or salary. Retiring in 2-3 years. Two-man office. Not doing hospital work, but open staff hospitals available. Good country. Congenial people. Professional and personal data requested. Send reply to: Box #9, c/o JOURNAL, 1211 Cathedral St., Balto., MD. 21201.

POSITION WANTED

LICENSED PHYSICIAN—Moving to Montgomery Co. in July. Desires evening or weekend work in general practice. Inquiries invited. Box 337, Duke Hospital, Durham, N.C. 27706

FOR SALE

PHYSICIAN'S HOME & OFFICE—Two buildings of stone construction with slate roofs. Each building individually maintained with central heating and a/c. Two bedroom home. Office has large waiting room, 2 exam-consultation rooms, 2 bathrooms. Buildings connected by a breezeway and porch enclosure—could be converted for other uses. Structures occupy one acre, center of a block on Liberty Rd, near Beltway Exit 18. Call: 653-6565 anytime.

CATONSVILLE—Most attractive brick home in very nice area. Large living room with fireplace, dining room, eat-in kitchen, our bedrooms, two full baths. Beautiful clubroom for entertaining with fireplace and bar. Office and waiting room makes home ideal for doctor. Exotic shrubbery enhances the professionally landscaped lot. Call: Rose M. Hess, 744-0892.

FOR RENT

PROFESSIONAL OFFICES—3501 Fait Ave, East Balto. Established medical practice (20 yrs). Opening for ophthalmologist, radiologist, otolaryngologist, dermatologist or dentist. Call: 866-8924 anytime.

PROFESSIONAL OFFICE—Available immediately. 2505 W. Belvedere Ave. near Sinai Hospital. Large office suitable for solo or joint practice. Off-street parking included. Formerly used by pediatrician. Will redecorate. Call: FO 7-3864.

Advertisers in This Issue

Abbey Rents 102
A & F Nurses Registry 126
Aids for Hearing 122
The Alcazar 117
Al-Lin Ambulance Service 134
Ann-Lee Laboratories, Inc. 42
Arundel Federal Savings & Loan Assoc. 34
Baltimore Nurses Exchange 135
Baltimore Oxygen Supply Co., Inc. 134
Belvedere Hotel 140
Bolton Hill Dinner Theatre 122
Brentwood Inn 34
Bristol Laboratories 35, 100
Broadview Restaurant 119
Burroughs Wellcome & Co., Inc. 94
Campbell Soup Company 55
Capital Savings & Loan Assoc. 135
Oscar Caplan & Sons 8
Chernock Storage Co. 124
Club Venus 119
Cobb-Woods Services 17
Coca-Cola Co. 122
Cork 'n Bottle Restaurant 119
Herbert Cox—Corrective Shoes 126
Dobbs House Restaurant 119
Doctors Supply Co. 126
Dulaney Towson Nurs. & Conv. Home 112
Eagle Printing Co., Inc. 112
Eastern Overall Rental Co. ..... 2nd Cover
Eastern Research Laboratories, Inc. ..... 3rd Cover
Eleven East Chase St. Corp. 21
Embassy Dairy 102
Evangelical Press 126
Fedder's Medical Services 8
Federated Business Services, Inc. 128
Fields Pharmacy 134
Food & Drug Administration 140
Forty West Volkswagen 102
Franklin Uniform Co. 127
Geigy Pharmaceuticals 30-32, 37, 92-93
Globetrotter Travel Services 124
Greenberry Woods 129
The Gundry Sanitarium 43
The Hecht Co., Northwood Rooftop Restaurant .. 119
Hidden Brook 124
High Fidelity House 128
Highland Hospital 7
Hood Convalescent Home 129
House in the Pines Nursing Homes 39
Hynson, Westcott & Dunning, Inc. 1
Jobst Service Centers 106
Johnson Funeral Home 114
Lederle Laboratories 2, 29, 42, 108, 117
Eli Lilly & Co. 12
Maico Hearing Aids, Inc. 42
Maria's 300 Restaurant 119
Md. Academy of Medical & Dental Assistants 111
Maryland Volkswagen 135
McNeil Laboratories, Inc. 36
Mercantile-Safe Deposit & Trust Co. 18
Metropolitan Washington Blood Banks, Inc. 117
Michaelson Motors, Inc. 105
Miller Brothers Restaurant 119
Milton Inn 119
Monarch Lincoln Mercury, Inc. 130
Murray-Baumgartner Surg. Instr. Co., Inc. 11
National Drug Co. 17
Palmer House Restaurant 119
Parke, Davis & Co. 38
Chas. Pfizer & Co., Inc., Pfizer Laboratories Division, Bonine 40-41
Pielke Landscape Services 130
W. C. Pinkard & Co. 34
Pleasant Manor Nurs. & Conv. Home 21
Wm. P. Poythress & Co., Inc. 29
T. Rowe Price Growth Stock Fund, Inc. 34
Professional Management Co. 11
Professional Systems & Services 132
Geo. Radebaugh & Sons 131
Read's Drug Stores 130
Resinol Chemical Co. 111
R & H Motors, Inc. 134
A. H. Robins Co. 22, 120-121
Roche Laboratories ..... 91, 4th Cover
Rose Exterminator Co. 112
Sandoz Pharmaceuticals 58
Manuel Schwartz 134
G. D. Searle & Co. 56-57
Special Diet Shop 124
Sterling Lighting Co. 117
Skill Surgical Instrument Co. 126
Mano Swartz—Furs 8
Therapeutic Appliances, Inc. 130
Tijuana Tacos 119
Towson Valley Volkswagen 130
Twentieth Century Auto Radio 127
Valley Mart 134
D. Stuart Webb Advertising Services, Inc. 117
Westview Lounge & Supper Club 119
White Rice Inn 119
Winthrop Laboratories 26
Zimmerman's Shoes 8

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number, the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.



after surgery...

To restore tissue depletion of Vitamin B Complex and ascorbic acid induced by the physiological stress of surgery, illness or injury—Increases the recuperative power of convalescence.

beta massive capsules

B COMPLEX WITH VITAMIN C



Thiamine HCl	B_1	10 mg.
Riboflavin	B_2	10 mg.
Pyridoxine HCl	B_6	5 mg.
Cyanocobalamin	B_{12}	4 mcg.
Ascorbic Acid	C	150 mg.
Calcium Pantothenate		20 mg.
Niacinamide		50 mg.

EASTERN RESEARCH LABORATORIES, INC.

302 S. CENTRAL AVE. · BALTIMORE, MARYLAND 21202



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:
Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, o summary of which follows:
Indications: Indicated when onxiety, tension ond apprehension ore significont components of the clinicol profile.
Contraindications: Patients with known hypersensitivity to the drug.
Warnings: Coution potients obout possible combined effects with olcohol ond other CNS depressants. As with all CNS-octing drugs, caution potient against hozardous occupations requiring complete mental alertness (e.g., operating mochinery, driving). Though physicol and psychological dependence have rorely been reported on recommended doses, use caution administering to addiction-prone individuols or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug ond similar to those seen with barbiturotes, have been reported. Use of ony drug in pregnancy, loctotion, or in women of childbearing oge requires that its potentiol benefits be weighed agains its possible hozords.
Precautions: In the elderly and debilitated, and in children over six, limit t smollest effective dosoge (initially 10 mg or less per day) to preclude ata or oversedation, increosing gradually os needed and toleroted. Not recommended in children under six. Though generally not recommended, combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiat drugs such os MAO inhibitors and phenothiazines. Observe usual precoutions in presence of impaired renol or hepatic function. Paradoxical reoctions (e.g., excitement, stimulation and ocute roge) have been reported in psychiotric potients ond hyperactive oggressive children. Emp usual precoutions in treotment of onxiety stotes with evidence of impending depression; suicidol tendencies moy be present and protective measur necessory. Varioble effects on blood coagulation have been reported ver rorely in potients receiving the drug ond oral onticoogulonts; causol relationship hos not been estoblished clinicolly.
Adverse Reactions: Drowsiness, otaxio ond confusion moy occur, especial in the elderly ond debilitated. These ore reversible in most instances by proper dosage odjustment, but are olso occasionally observed at the low dosage ranges. In o few instances syncope hos been reported. Also encountered ore isoloted instonces of skin eruptions, edemo, minor menstru irregularities, nauseo ond constipation, extropyromidal symptoms, increc and decreased libido—oll infrequent ond generally controlled with dosag reduction; chonges in EEG patterns (low-voltage fost activity) moy oppea during and after treatment; blood dyscrosios (including agranulocytosis), joundice ond hepotic dysfunction hove been reported occasionally, maki periodic blood counts and liver function tests advisoble during protractec therapy.

WA
MA791
EADING
ROOM



aaron Sopher

JTC: L SX
INDEXER:
VOL-ISS:
DATE:
DEPTH:
NON-DEPTH:
RUSH:
SELECTIVE:

NATIONAL LIBRARY OF MEDICINE
RECD. JUN 24 1969
INDEX
INPUT

Maryland State Medical Journal

OFFICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

VOLUME 18 NUMBER 6
JUNE 1969

600 ROCKVILLE PIKE
BETHESDA MD 20014

RESORT HOTEL?

NO!



COUNTRY CLUB?

NO!

This is a licensed PSYCHIATRIC HOSPITAL

Accredited by the Joint Commission on Hospital Accreditation

Can your patient afford this ultimate luxury in psychiatric care and environment where there are special programs for Adults, Adolescents, Alcoholics, Narcotics, all Mental and Nervous Disorders? **YES!**

since most insurances now pay part of psychiatric treatment and the charges are consistent with other hospitals.



Ruby Dining Room



Turquoise Lounge



Patient Lanai Bedroom



Pool Patio

For further information and rates please call 465–3322, or write

Taylor Manor Hospital

Ellicott City, Maryland 21042

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

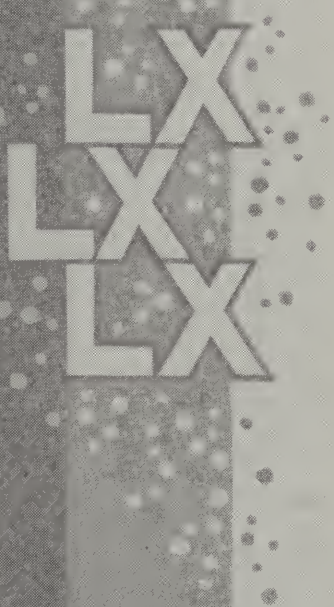
No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

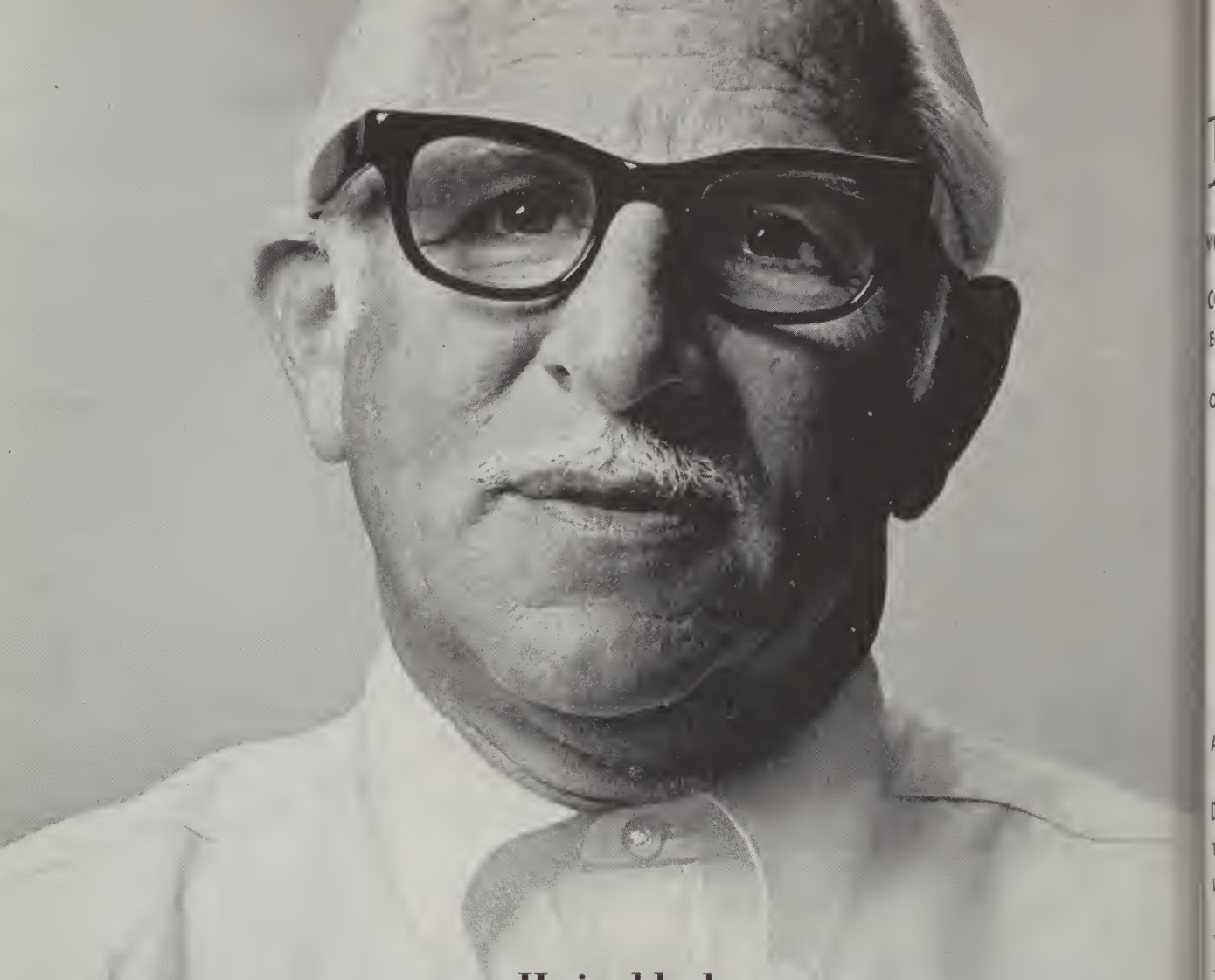
HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., 319-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 15. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D.J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Aes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Cal Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.



He is elderly,
he is on corticosteroids,
when he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appro measures should be taken.

In infants, increased intracranial pressure with bulging fontane been observed. All signs and symptoms have disappeared rapidly cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting rhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—macu ular and erythematous rashes; a rare case of exfoliative dermatit been reported. Photosensitivity; onycholysis and discoloration nails (rare). Kidney—rise in BUN, apparently dose related. Tra increase in urinary output, sometimes accompanied by thirst (Hypersensitivity reactions—urticaria, angioneurotic edema, anaph Teeth—dental staining (yellow-brown) in children of mothers give drug during the latter half of pregnancy, and in children given th during the neonatal period, infancy and early childhood. Enamel plasia has been seen in a few children. If adverse reaction or i crasy occurs, discontinue medication and institute appropriate th

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Sho given 1 hour before or 2 hours after meals, since absorption is im by the concomitant administration of high calcium content drugs and some dairy products. Treatment of streptococcal infections continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES, A Division of American Cyanamid Co Pearl River, New York

Maryland State Medical Journal

VOLUME 18 JUNE 1969 NUMBER 6

CONTENTS:

Editorial—Your Pathologist is a Practicing Physician Like Yourself—Be Loyal to His Local Laboratory, John F. Schaefer, MD **60**

Occipital Neurectomy in the Treatment of Headache—Results in 30 Cases, J. Peter Murphy, MD **62**

"The primary treatment of any headache problem is, and properly should be, medical management. If a therapeutic response is not prompt and satisfactory, the next step is to investigate further whether or not an intracranial source of the chief complaint exists. . . . Psychic conflict and repressed aggression are so well recognized to be a competent producing source of pain in the cranial or cervical regions that expressions such as "a real headache" or a "pain in the neck" are used in all languages to describe or refer to situations or associations which inspire frustration, antagonism, or rage. It is my belief, however, that the concept of "tension headache" has been so widely and thoroughly oversold that many patients are denied the opportunity to obtain effective relief from headache-producing cranial or cervical neuralgias by surgical means."

Annual Reports **67**

DEPARTMENTS:

Traffic Safety—The Cardiac Patient and Driving, Robert J. Wilder, MD ... **29**

Library Page—What Kinds of Questions is a Medical Reference Library Asked? **33**

Your Medical Faculty at Work, John Sargeant **108**

Tuberculosis—Tuberculin Testing Program **109**

Baltimore City Health Department—Mayor's Task Force on Nutrition **111**

Maryland State Department of Mental Hygiene—On the Care of the Mentally Subnormal **115**

Alcoholism—Medical Team Sketches Portrait of Alcoholic **117**

Rehabilitation Notes—Osteoarthritis of the Hip, Norton I. Gettes, MD **119**

Heart Page—Antibiotic Chemoprophylaxis in Cardiac Surgery, Morton I. Rapoport, MD, and Rolendo Sabundayo, MD **129**

Doctors Take Note **5** Semiannual Meeting **7** AMA Prepares Position Papers on Reasonable Charge Criteria **13** Vaginal Contraceptives Still Essential **14** Book Reviews **16** The Month in Washington **24** Report on Joint Meeting with the Standards Committee of the Joint Commission on Accreditation of Hospitals **31** Minutes of the House of Delegates' Meetings in April **35** Medical News **49** ACS to Establish Organ Transplant Registry **131** Resort Advertisers' Index **137** Skilled Hands for the O.R. **143** Classified Advertising **148** Advertising Index **149**

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland.

Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

ON THE COVER: Aaron Sopher has again given us permission to exhibit another one of his classic sketches. This one seems to typify the average American family on a summer vacation at the beach. The Journal staff wishes you a pleasant summer and, no matter where you go, take a copy of the Journal along for interesting and informative reading.

Reserve September 4-6 for the Faculty's Semiannual Meeting in Hershey, Pa. Plan to Attend!



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

900252

Doctors take note...

JUNE 22-26, 1969
AIR POLLUTION CONTROL ASSOCIATION

62nd Annual Meeting: Americana Hotel, New York. Chairman: Austin N. Heller, Commissioner of Air Resources of New York city. Contact: Bill Oliver, Tel. (212) 686-4700 or Bill Farley, (212) 460-4111.

JUNE 23-26, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Valvular Heart Disease, The Basis For Selecting Treatment: University of Oregon Medical School, Portland, Oregon. Co-Directors: Herbert E. Griswold, MD, FACP, and Howard P. Lewis, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

JUNE 27-29, 1969
HEART ASSOCIATION OF MARYLAND

Western Maryland "Weekend With Doctors": Frostburg State College. For further information contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Maryland 21201.

JULY 7-11, 1969
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

Postgraduate Course—Clinical Electrocardiographic Interpretation: Marriott Motor Hotel, Philadelphia, Pa. Director: Leonard S. Dreifus, MD. Contact: Sage Cordell, Assistant Director, Continuing Education, Hahnemann Medical College and Hospital, 230 North Broad St., Philadelphia, Pa. 19102.

JULY 14-18, 1969
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

Postgraduate Course—Interpretation of Cardiac Arrhythmias: Marriott Motor Hotel, Philadelphia, Pa. Director: Leonard S. Dreifus, MD. Contact: Sage Cordell, Assistant Director, Continuing Education, Hahnemann Medical College and Hospital, 230 North Broad St., Philadelphia, Pa. 19102.

A & F Nurses Registry



LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

Registered & Licensed

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.
BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

Visit the #1 Spot for Your Diet Needs

Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)

For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic

SPECIAL DIET SHOP
Phone SA 7-0383

Enjoy INCOME or GROWTH with



5% Savings Certificates

*GROWTH CERTIFICATES from $3,000 up; interest compounded quarterly after the first six-month period, and accumulates until maturity, in three years (or redeemable on any interest date without penalty).

*INCOME CERTIFICATES from $3,000 up; interest is mailed or credited to checking or passbook savings account of owner every six months until maturity, in three years (or redeemable on any interest date without penalty).

Stop in at your neighborhood Union Trust office and put your money to work earning 5% per annum.

UNION TRUST
COMPANY OF MARYLAND

MAIN OFFICE: Baltimore and St. Paul Sts. Metropolitan Baltimore and Eastern Shore Offices

Member: Federal Reserve System, Federal Deposit Insurance Corp.

The red carpet will be rolled out for the Semiannual Meeting of the Medical and Chirurgical Faculty

Thursday, Friday, Saturday, September 4, 5, 6, 1969

at the

Hotel Hershey, Hershey, Pennsylvania

SCIENTIFIC SESSIONS, BUSINESS MEETINGS, TOUR OF THE NEW HERSHEY MEDICAL CENTER, TOURS OF THE AMISH COUNTRY AND CHOCOLATE FACTORY FOR THE LADIES, GOLFING, MONTE CARLO NIGHT, COCKTAIL PARTY AND BANQUET

Included in the scientific sessions:

- Case presentations on current treatment programs for narcotic addicts
- All aspects of trauma will be discussed by a panel arranged by Maryland Chapter, American College of Surgeons
- Maryland Psychiatric Society program
- Maryland Association of Nursing Home Physicians program
- Maryland Society for Rheumatic Diseases program
- Maryland Diabetes Association program
- Luncheon meeting of MMPAC (Maryland Medical Political Action Committee)

A weekend worth planning for well in advance. There will be many scientific sessions and social functions of interest to all physicians and their families. Complete and mail the hotel reservation below TODAY. More about the program later!

DeWitt E. DeLawter, MD, Chairman
Committee on Program and Arrangements

Medical and Chirurgical Faculty of Maryland

HOTEL HERSHEY

September 4, 5, 6, 1969

PLEASE CHECK THE APPROPRIATE SPACES AND RETURN PROMPTLY TO:

Mr. Harvey S. Schell, Reservations Manager
Hotel Hershey, Hershey, Pennsylvania 17033

ROOM RATES: AMERICAN PLAN, WITH MEALS

Twin-bedded rooms .....$24.00 per person per day—2 in a room

Single rooms .....$27.00 per person per day

(A 15% Gratuity to be added to the above rates. This takes care of the Dining Room Personnel on food only, bellmen for check in and out, maids and doormen. Individuals to do other tipping on their own, such as room service, beverage bills, etc.)

PLEASE RESERVE THE FOLLOWING ACCOMMODATIONS:

.....Twin bedded rooms

.....Single rooms

..... NAME OF MEMBER SHARING ROOM

ARRIVAL DATE..... DEPARTURE DATE.....
(ROOMS NOT AVAILABLE UNTIL 4:00 P.M.) (1:00 P.M. CHECK OUT TIME)

.....
DATE



Diamonds Come In Many Shapes

A unique shape diamond in its appropriate mounting creates a remarkably different and most unusual ring.

Besides the round, there are heart shapes, emerald cut, pear shapes, crescents, marquise, half moons, tapered, square cut, baguettes, etc.

We'd like you to see these out-of-the-ordinary diamonds.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

Exclusively in Maryland

FUR DESIGNS APPROVED BY WORLD-FAMED

Oleg Cassini

★



Mano Swartz

225 N. HOWARD ST.

MARYLAND'S OLDEST AND LARGEST FURRIER

We recommend CAMP

PENDULOUS ABDOMEN SUPPORTS



Specifically designed to balance the load of forward bulk in obese patients; affords relief of strain on muscles and ligaments of the back and feet in the ankle-joints, caused by weight-accented spinal curve, bowed head and rounded shoulders. These supports often improve circulation and digestive disturbances.

DONALD O. FEDDER, ORTHOTIST

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

BALTIMORE, MD.

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.

executive secretary's newsletter

June, 1969

DEADLINE FOR RESOLUTIONS

The deadline for resolutions to be considered at the Semiannual Meeting of the Faculty is:

FRIDAY, JULY 11, 1969

Any resolutions must be in the Faculty office by 5:00 p.m. on that date.

The Reference Committee meeting during which any resolutions will be discussed, is scheduled for:

THURSDAY, AUGUST 14, 1969

at 7:30 p.m.

ECONOMIC FACTS OF LIFE

A recent study, completed by the Association of American Medical Colleges, indicates that salaries of full-time faculty at schools of medicine range from a low of $18,000 in pediatrics to a high of $40,000 in surgery (as chairman).

Low figures apply to assistant professorships. The highs refer to department chairmen. Listed by specialty the salaries are:

Anesthesiology	$25,000	$36,800
Medicine	19,000	36,000
Obstetrics-Gynecology	20,000	36,000
Pathology	19,200	34,400
Pediatrics	18,000	35,000
Psychiatry	20,000	35,900
Radiology	25,000	40,000
Surgery	22,000	40,000

Union plumbers in Philadelphia recently were given a new contract which raised their hourly wage to $9.76; or a total of $19,520 for a 40 hour work week.

In San Francisco, plumbers recently negotiated a new contract to raise their hourly rate to $10.65.

MED-CHI SEMIANNUAL MEETING

A program of interest, both scientifically and socially, to physicians and their families has been scheduled at the HOTEL HERSHEY on THURSDAY, FRIDAY, AND

MED-CHI SEMIANNUAL MEETING (cont'd)

SATURDAY, SEPTEMBER 4, 5 and 6. (See elsewhere in the Journal for further information about the program and a hotel reservation form.) MAKE YOUR RESERVATIONS NOW!

SCIENTIFIC EXHIBITS FOR 1970

The Committee on Program and Arrangements of the Medical and Chirurgical Faculty is interested in obtaining scientific exhibits from members for displa at the 1970 Annual Meeting, April 1, 2 and 3, in Baltimore. Contact the Faculty office for further information.

FACULTY INSURANCE PROGRAMS PAY OFF

Members of the Faculty's Insurance Programs receive welcome news recently when it was announced that benefits would be broadened and premiums reduced, at the same time.

The increase in benefits includes:

Major Medical Maximum Benefit is now up to $20,00

Daily Private Room limit has been raised to $60.

Co-insurance increase now covers up to 90%

Automatic additional life insurance for members and dependents

The rate reduction, scaled by age groups, would var with the coverage carried by the physician.

GENERAL MEETING ON INCORPORATION

A general meeting for Faculty members, their legal advisers and tax consultants, has been set to discus the recently enacted Incorporation of Self-Employed Persons Act.

It will be held at the Faculty building on

TUESDAY, JUNE 24, 1969, at 7:30 p.m.

No reservations are required.

John Sargent

Executive Secretary

YOU CAN BE SURE

DOCTOR

YOUR SYSTEM ALSO NEEDS
PERIODIC CHECK-UPS . . .
IMPROVED ROUTINES AND
POSITIVE CONTROLS

℞

◆

All change is not progress—but seldom is progress ever made without change.

◆

OUR SERVICE
OFFERS YOU

MAXIMUM CONTROL AND SAFETY
FROM BALANCING RECORDS AND
MINIMUM EFFORT ON YOUR PART

◆

FINANCIAL MANAGEMENT
CAN HELP YOU

◆

DIAL 752-5920

Professional Management Co.

914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN



Meet the new Tycos wall mounted Aneroid. You can read it from anywhere in the room.

- Big 6¼" dial. Large black numerals on white background. Easy to read from anywhere in the room.
- Positive swivel action for setting in several positions on stainless steel bracket.
- Non-glare neutral case. No chrome. Shatterproof crystal. Simple in design and easy to clean.
- Visual check for accuracy — exclusive with all Tycos aneroids.
- Choice of hook or velcro cuffs. 6-foot coiled cord standard.

Murray Baumgartner

Surgical Instrument Co., Inc.

2501 Gwynns Falls Parkway at Warwick Ave.
Phone: 669-9300 Baltimore, Md. 21216

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And free your secretary to be your secretary again.

professional systems and services *division of*

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3886



AMA Prepares Position Papers On Reasonable Charge Criteria

Implementation of proposed changes for determining reasonable charges under the Medicare Part B program "would impair existing relationships between Part B carriers, physicians and government," said Ernest B. Howard, MD, Acting Executive Vice President of the American Medical Association, in a recent letter to HEW Secretary Robert H. Finch.

SSA Directive

The Social Security Administration, in a December 17th instructional letter to the Part B carriers, categorically stated that, "Prevailing charge limits should be established by calculating the mean of the customary charges for a given service and adding one standard deviation above the mean (rounded out to the nearest dollar), or the equivalent."

Position Papers

The AMA Council on Medical Service, Dr. Howard noted, is in the process of preparing position papers on six specific subject areas relating to the directives. They are:

—Determination of reasonable charges for physicians' services—interrelationship to usual, customary and reasonable fees and to prevailing fees concepts.

—Procedures relating to development and application of (a) physicians' fees profiles, and (b) screen of prevailing charges in area.

—Considerations involved in submitting charges for physicians' services—itemized billing, all-inclusive charges billing, direct billing and assignments.

—Charges for services obtained from an independent laboratory.

—Charges for physicians' services in teaching institutions—patterns employed to distinguish between patient care and teaching activities.

—Peer review of physicians' fees and utilization of health care services.

The Council intends to use the position papers, supplemented by information obtained in discussions with the carriers, as the basis for consultation with Secretary Finch and other HEW officials.

The Council held a meeting on March 27 with members of the Blue Shield Government Programs Committee to obtain their views on these subjects.

HOOD CONVALESCENT HOME

"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF

CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED

National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM

Certificate Holder—Baltimore County
Fire Prevention Bureau Award

LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800

5313 EDMONDSON AVE.

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

FLORISTS TELEGRAPH DELIVERY F.T.D.

Geo. **RADEBAUGH** *& Sons*

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300

Vaginal Contraceptives

Far from having "historical interest only" in the age of oral contraception, other methods of birth control deserve careful consideration in patients for whom orals are inadvisable. . . . Physicians should not have an orals-or-nothing attitude toward family planning because many of the other contraceptive methods have improved "remarkably" of late, and can provide excellent protection when carefully used.

These are among the major points made in a symposium held recently at The Johns Hopkins University School of Medicine. "Vaginal Contraception In The Era of the Pill" was the subject of the conference, sponsored by Ortho Pharmaceutical Corporation.

"We have two methods which provide the potential for meeting the threat of overpopulation—oral contraception and the intrauterine device," said Nicholson J. Eastman, MD. But the Professor of Obstetrics Emeritus at Johns Hopkins added, that for the minority of women unsuited to such regimens, "something must be done to provide alternate methods of conception control."

Three fourths of women discontinuing orals return to methods they used previously, according to Charles F. Westoff, PhD, professor of sociology at Princeton University. Many of the others turn to contraceptive foam, a method even newer than the pill.

"There are various methods available at the present time," said Aquiles J. Sobrero, MD, director of the Margaret Sanger Research Bureau in New York. "Many, especially the jellies and cream, have improved remarkably in efficacy in the last ten years. We also have a brand-new method—foam—which is very much 'in.'"

Dr. Sobrero called it "distressing" that "so few data are available on the effectiveness of the diaphragm. . . ." But Dr. Westoff told the conference at Johns Hopkins that "if properly inserted and



WHEN YOUR PATIENTS NEED
NURSING CARE

Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED

24 HOUR SERVICE ESTABLISHED 1935

BALTIMORE, MARYLAND 21229

Still Essential, Symposium Informs

properly used, the failure rate of the diaphragm is practically zero."

Diaphragms are "still the best method for private patients who do not want or cannot use the pill," added Herbert H. Thomas, MD, clinical associate professor of obstetrics and gynecology at the Medical College of Alabama. And Georgeanna Seegar Jones, MD, associate professor of gynecology and obstetrics at Johns Hopkins, agreed that when diaphragms are fitted properly—and patients instructed in their use—they offer almost 100% effectiveness.

Ideally, there should be "a total contraceptive program," said Dr. Sobrero, so that women do not feel "afraid to come back and displease the doctor" by admitting they are dissatisfied with the pill. "But first, it is necessary to bridge the gap between the doctor and patient, and get the woman to take the initiative and ask for birth control information. Then it is necessary to overcome the indifference of many doctors about recommending birth control or devoting the necessary time to this health measure."

Age also can be an important factor in conception control, the symposium brought out. The older patient is more likely to discontinue the pill than is the younger, and the age of the physician may influence the contraceptive method selected.

"Part of the problem lies in our medical schools," declared Dr. Thomas. "They should be encouraged to teach all methods of contraception. Another educational medium which I think should be encouraged is the lay press. Articles favorable to vaginal contraception will help inform women about adequate contraception and also encourage doctors to learn about types of contraceptives other than the pill.

"Both the public and the medical profession need to be educated about methods of birth control other than oral contraceptives. In the final analysis, it is the degree of patient and doctor motivation, along with proper instruction of the patient, that determines effectiveness," he stated.

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery MU 5-3232

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202

NOW

A NEW CONCEPT

in

BOOKEEPING

and

TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

FEDERATED BUSINESS SERVICES, INC.

Box 580
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager



LUNG CANCER, A STUDY OF FIVE THOUSAND MEMORIAL HOSPITAL CASES, William L. Watson, MD; The C. V. Mosby Company, St. Louis, 1969.

While William L. Watson, MD, is listed as the author of this publication, it was co-authored by many distinguished and well-known specialists in the field of cancer and cancer research. Its aim is to present, in a reasonable space and accessible form, the main features of the origin, structure, natural history, and modern treatment of lung cancer.

The concepts, as well as the guidelines described, differ considerably from those in other publications on the same subject. The data on this one anatomic form of cancer have been accumulated during the past 40 years at the Memorial Hospital, New York city. Each of the many facets of the lung cancer problem is reported by a specialist in his own field, yet a certain homogeneity is provided by the fact that each writer is a member of the same medical center, and each is well grounded in the general field of oncology.

This study of 5,000 cases of lung cancer makes it possible to take the somewhat advanced position that cell type is of the greatest clinical importance in regard to the life history, etiology, prognosis, and form of treatment.

This is a book well worth reading, and adding to your medical library.

COLLATERAL CIRCULATION IN CLINICAL SURGERY, D. E. Strandness, Jr., MD; The W. B. Saunders Co., Philadelphia, 1969.

The purpose of this book is to discuss, in detail, diseases in which a consideration of collateral circulation is important. In most instances, these diseases are involved in the development of collateral circulation.

In each area considered, attention is devoted to normal anatomy, congenital variations, and the available collateral pathways. These discussions include the consideration of the signs and symptoms pertinent to disease location and collateral circulation. Methods of evaluation and interpretation are stressed; and application of modern study techniques is covered in detail wherever applicable.

This book is designed for the experienced physician, vascular surgeon, and surgical specialist, as well as the house officer.

DIAGNOSIS AND MANAGEMENT OF PAIN SYNDROMES, Bernard E. Finneson, MD; The W. B. Saunders Co., Philadelphia, 1969.

Six years have elapsed since the first publication of this volume, and enough changes have taken place to warrant a reworking of the text. However, most of the changes incorporated into this book, and the techniques described, are widely accepted and no claim is made for original methods or any "new concept".

A number of the techniques fall solely within the discipline of neurosurgery and are not intended as an inducement to those not trained in this field. An appreciation of the available operative procedures is helpful to anyone involved in the management of pain.

CURRENT THERAPY, 1969, Howard F. Conn, MD, and other consulting editors; The W. B. Saunders Co., Philadelphia, 1969.

This volume marks the beginning of the third decade of publication of Current Therapy. It is assumed that physicians using this volume have intimate knowledge of the detailed information available in the official product circular for each drug before prescribing the drug for their patients.

The therapeutic action of most drugs mentioned is under continuous clinical evaluation and, from time to time, new uses, changes in dosage, the appearance of unexpected contraindications, and adverse reactions are reported. The articles have been written by physicians prominent in their respective fields, and represent a careful distillation of the vast amount of information available to the therapist today.

The fact this publication has been published and used for 20 years, should indicate its usefulness to all.

Why take chances.
Why not let CHERNOCK guard your valuable key records in their modern, safe, fireproof warehouse.
Surprisingly inexpensive.
CHERNOCK
MOVING & STORAGE
PHONE 685-7630



The doctor who doesn't have the proper prescription for planning his estate is inviting a bad case of unnecessary taxes. How about you? If you're vulnerable, we and your attorney have the cure. Call our Dick Flanigan at 539-1040 and arrange an appointment. You needn't wait for our new building to be completed either. We make house calls.

MERCANTILE-SAFE DEPOSIT and TRUST COMPANY



CCTV TOTAL SYSTEMS

PLANNING, ENGINEERING, INSTALLATION & SERVICE

We Feature **AMPEX**

VIDEOTAPE RECORDING EQUIPMENT

Call Today for a Free Demonstration

high fidelity house

6307 YORK ROAD BALTIMORE, MD.
(Drumcastle)

Phone 323-3713



Traditional Japanese Cuisine

SUKIYAKI TEMPURA
TERIYAKI SUSHI

. . . and others

COCKTAILS AND MIXED DRINKS

SAKE (RICE WINE)

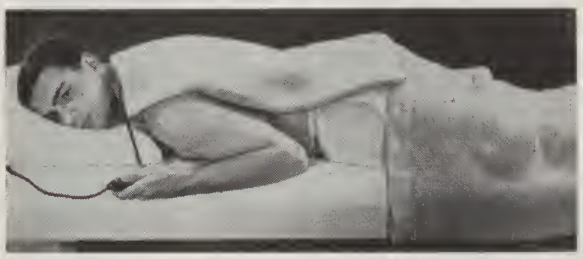
JAPANESE BEER— ASAHI AND KIRIN

11 A.M.—11 P.M.
CLOSED MONDAY

SAKURA PALACE

7926 Georgia Ave., Silver Spring, Md. 20900
JU 7-7070

Now When You Recommend Moist Heat,



Recommend Automatic Moist Heat.

Until now, application of moist heat required boiling water, hot towels, and somebody to apply them. The Battle Creek THERMOPHORE changes all that. It provides instant and automatic moist heat, intensely hot, deeply penetrating.
The patient simply plugs it into an outlet. This unique hot fomentation pad then generates its own moisture from the air. Intensely hot moist heat is constantly maintained, and evenly distributed throughout the pad. No water is needed, no filling or emptying is required.
Large 13" x 27" pad covers back, or chest and abdomen, or both legs. Safety thermostat turns it off automatically, prevents overheating.
Price is **$35.00.** Also available in medium size 13 x 13 **$25.00.**

Phone for Free Descriptive Literature, or See It At . .

THERAPEUTIC APPLIANCES, INC.
JULES MORSTEIN
1114 Light St. **Phone 752-6996**
Baltimore, Md. 21230

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ **INGLESIDE SHOPPING CENTER**
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ **HILLENDALE SHOPPING CENTER**
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

his ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

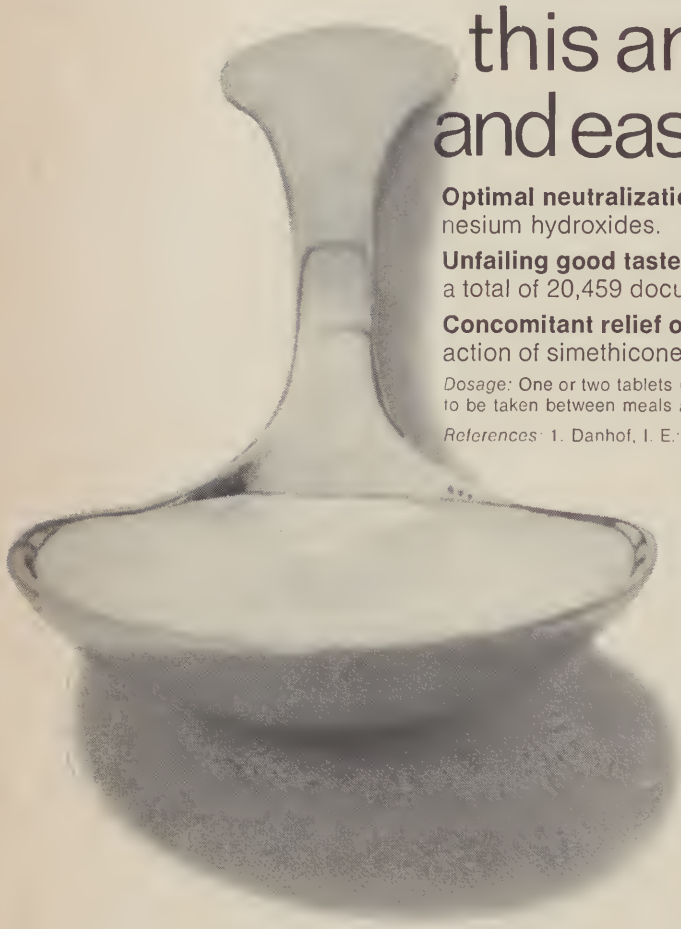
Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8



The go-ahead-and-enjoy-your-vacation summer cold and allergy pill.

vahistine LP lets you provide effec-
e relief of summer cold and allergy
nptoms, lets your patients go ahead
d enjoy their vacations.
ese continuous-release, deconges-
t tablets contain a vasoconstrictor-
ihistamine formulation that goes
work promptly and lasts for hours.
n the nasal congestion resulting
m repeated allergic episodes can
ually be relieved by Novahistine LP.

And, convenient twice-a-day dosage lets most patients enjoy relief all day and all night. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

THE MONTH IN WASHINGTON

Health, Education and Welfare plans to impose Blue Shield schedules for physicians under Medicaid, and to limit payments to hospitals under Medicaid and Medicare, drew strong responses from the American Medical Association and the American Hospital Association.

Dwight L. Wilbur, MD, president of the AMA, urged in a letter to Robert H. Finch, HEW Secretary, that all segments of the health care field be consulted in effecting economies in government-paid health services.

"The American Medical Association is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the principal providers of health care to all the people," Dr. Wilbur said. "The needs and problems of patients in all walks of life, at all income levels, come to their attention, in composite, more than a billion times a year.

"It has always been a principle of both the humanity and the professional code of the physician that no one shall ever be denied quality health care because of his inability to pay. The present concern is how this universal care can best be provided within a viable economic system and in the face of burgeoning demand for medical manpower, services, and facilities. . . .

"The knowledge and judgment of the nation's physicians —as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others —must be enlisted in your battle against the health-care portion of the inflation problem."

Dr. Wilbur wrote Finch following the HEW announcement that federal spending on the Medicaid-Medicare programs would be trimmed by $328 million through imposing Medicaid fee schedules based on prevailing Blue Shield rates, limiting mental illness benefits under Medicaid, and cutting down hospital overhead allowances in Medicaid and Medicare.

"It is important to recognize that there are many variables in the circumstances of payment for medical and hospital services," Dr. Wilbur stated. "Local needs and resources, the educational and motivational levels of the people, the economic conditions of the state and the community are among the reasons for the differences exhibited by the payment patterns of the Blue Shield plans and health-insurance companies.

"These circumstances must be the foundation for any policies involving cost and payments. No universal pattern—no matter how many variations it may try to provide—can be imposed on the thousands of localities without wreaking havoc and probably increasing inefficiency and costs."

Concerning the imposition of Blue Shield rates as fee schedules under Medicaid, Dr. Wilbur warned, in an address before the American Society of International Medicine in Chicago, that a later step "might be that of physicians, in groups, being placed on salary, and, therefore, abandoning the fee-for-service principle." He said that physicians, in combatting such government efforts, must accept the major responsibility of keeping fees as moderate as possible.

The American Hospital Association protested, in a letter to President Nixon, against removal of the 2% overhead allowance for hospitals. Officially representing the AHA, Ray R. Eppert, a hospital trustee from Detroit, said in a memorandum accompanying the letter to Nixon:

"The recent announcement of a reduction in Medicare reimbursement poses a serious threat to institutional integrity and, therefore, to the ability of hospitals to serve the sick and injured of this nation. Hospitals have been repeatedly assured, at the highest levels of government, that Medicare changes would not be made without consultation with their designated representative, the American Hospital Association.

"The AHA has tried repeatedly, but unsuccessfully, to meet with Secretary Finch. It is incredible that the federal government would propose, without any consultation, removal of the 2% allowance which is a proper component of reasonable costs guaranteed under the law as passed by the Congress.

"The department apparently deemed it unnecessary to consult with the hospital field, and, as far as can be determined, made no serious study of the effect of the proposed reduction on hospitals. Payment of nothing but raw costs will lead . . . to the serious underfinancing of our hospitals."

* * *

Drug combinations became the target of the Senate Small Business Subcommittee's investigation of the prescription drug industry.

Medical school professors, critical of drug combinations, were called as witnesses in two days of hearings opening this phase of the drug industry probe which began nearly two years ago. It was not indicated when, or even whether, drug company representatives would have an opportunity to defend their combination products before the subcommittee.

Dr. Heinz F. Eichenwald, MD, a National Academy of Science drug specialist, and pediatrics chairman, University of Texas Southwestern Medical School, told the subcommittee that "misleading advertising" had lured "the gullible physician" into prescribing useless, and sometimes dangerous, drug combinations. He also said continued use of drug combinations "amounts to a strong indictment of the ability of many physicians to judge what is effective and what isn't."

Dr. Eichenwald and William M. M. Kirby, MD, a medical professor at the University of Washington Medical School in Seattle, testified on combination drugs on the opening day of hearings conducted by the subcommittee headed by Sen. Gaylord Nelson (D., Wis.).

The two physicians were among 30 drug experts who evaluated combination drugs for the National Academy of Science. The experts' unanimous report said the combinations were useless and sometimes dangerous.

The report caused the U.S. Food and Drug Administration to serve notice April 2, that the 78 combination drugs studied by the scientists would be banned from the market unless drug makers could prove the Academy studies were wrong. In many cases, drug companies are fighting the FDA order.

Eichenwald and Kirby both testified that physicians are widely prescribing the combinations despite numerous warnings of their potential danger.

Eichenwald said drug firms point to the admittedly widespread use of combinations to state that physicians must therefore have demanded them.

"The opposite is true," Eichenwald's prepared testimony said. "The demand was created by misleading advertising."

In another action, Nelson, D-Wis., urged the FDA to restrict cyclamate-sweetened products to a prescription-only basis.

In a letter to FDA, Nelson said "tens of millions of children and adults across the nation are unwittingly being exposed to potentially serious health hazards by the unnecessary consumption of cyclamate-sweetened soft drinks, cereals, desserts and 'sugar'-coated pills."

He added, "increasing scientific evidence indicates that cyclamates can cause chromosome breakdown, the birth of undersized offspring in animals, interference with effectiveness of certain antibiotics, persistent diarrhea, liver diseases, skin irritation and eruption, difficulty with blood clotting, and high blood pressure."

Cyclamate was originally developed as a sugar substitute for diabetics and others forced to restrict their intake of sweets. The FDA recently proposed regulations on labelling and ingredient content for cyclamate, often used now as a general substitute for sugar.

* * *

The Joint Commission on Mental Health of Children is recommending a broad program aimed at bettering the health of the nation's children and youths at an estimated cost of $6 billion to $10 billion a year.

The commission recently disclosed its recommendations to the annual meeting of the American Psychiatric Association in advance of its report to Congress. The 54-member commission—which has completed a three-year, $1.5 million study—was established by Congress in 1965.

Sen. Abraham A. Ribicoff (D., Conn.), who introduced the legislation to set up the committee, said he would promptly introduce legislation to carry out the commission's recommendations.

The recommendations included national health insurance for persons up to 21- or 25-years-old; family planning and birth control; prenatal care; pediatric care for children up to age three, and physical and mental health services for older children.

Other recommendations included: ● Federal funding for about 100 child-development councils to help guide families through the confusion of Government agencies in order to insure diagnostic, treatment, and preventive services for children ● Appointment of a Presidential council of advisers on children and youth, similar in position and prestige to the Council of Economic Advisers ● Establishment of state commissions and local authorities on child care ● Federal financing of about 10 evaluation centers to consider the working of the child development councils ● Publicly-supported day care available for all children ● Federal funds for training child health and weifare personnel ● Tax incentives to induce people to serve in slum areas.

Reginald S. Louri, MD, a Washington, D.C., psychiatrist, is chairman of the joint commission.

President Nixon, in a Feb. 19 message to Congress said:

"So crucial is the matter of early growth that we must make a national commitment to providing all American children an opportunity for healthful and stimulating development covering the first five years of life."

* * *


"I feel
so light-
headed..."

She's confused...and frightened. Yesterday, her complaint was a brief spell of dizziness. Next week, she may be troubled by prolonged nausea or tinnitus. The symptom of vertigo is a constant problem in geriatrics, and regardless of origin, duration, and frequency, such episodes can result in severe emotional and physical discomfort for the aging patient.

You can help prevent such problems with

BONINE®

(MECLIZINE HCl)

protects most patients against nausea and vertigo up to 24 hours with a single dose.

Whether the symptoms are due to Ménière's syndrome, labyrinthitis, vestibular dysfunction, or cerebral arteriosclerosis, most patients with nausea and vertigo respond remarkably well to Bonine (meclizine HCl). A single dose usually protects up to 24 hours. In difficult cases multiple daily doses may be necessary for maximum response.

One-a-day dosage costs your patients less. And fruit-flavored Bonine chewable tablets are more convenient to take anytime, anywhere—without water. Side effects are infrequent and mild, even with prolonged use.

Precautions: Although the incidence of drowsiness and atropine-like side effects such as dry mouth and blurring of vision is low, the physician should alert the patient to the need for due precautions when engaging in activities where alertness is mandatory. *Use in women of childbearing age:* In weighing potential benefits vs. risk in women of childbearing age, consider the fact that a review of available animal data reveals that meclizine exerts a teratogenic response in the rat. In one study a dose of 50 mg./kg./day (50 times the maximum recommended human dose) produced cleft palate in 2 of 87 fetuses when administered to the rat at critical times during the first 15 days of gestation. At doses of 125 mg./kg./day, meclizine will produce 100% incidence of cleft palate in the rat. At doses of 25 mg./kg./day, decreased calcification of the vertebrae and relative shortening of the limbs were also produced in the rat, but experts disagree as to whether this is a teratogenic response. While available clinical data are inconclusive, scientific experts are of the opinion that this drug may possess a potential for adverse effects on the human fetus. Consequently, consideration should be given to initial use of a nonphenothiazine agent that is not suspected of having a teratogenic potential. In any case, the dosage and duration of treatment should be kept to a minimum.

Supply: 25 mg. scored tablets.

More detailed professional information available on request.

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®
brand of dextroamphetamine sulfate and amobarbital
Spansule®
brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories



From the Subcommittee
on Traffic Safety of
the Medical and Chirurgical
Faculty of the
State of Maryland

The Cardiac Patient and Driving

ROBERT J. WILDER, MD
Assistant Professor of Surgery
The Johns Hopkins University
Attending Surgeon
Sinai Hospital
President, Metropolitan Division
Maryland Heart Association

For the welfare of their patients and for all citizens, the physician must judge the ability of an individual to drive safely. There are few guidelines at the present time, but more and more scientific research is being conducted. The 1968 report from the California State Department of Public Health [1] reveals that 15% of drivers dying within 15 minutes of their single vehicle accident died of natural causes, but most important is that 94% of these were due to heart disease. Coronary artery disease was the major culprit and this information points up the need for driving restrictions on patients with heart disease.

From the standpoint of public safety, heart disease is a tremendous problem: over 5,000,000 people die every year in this country from coronary artery disease, and many hundreds of thousands from other forms of arteriosclerotic disease that cause sudden death or loss of consciousness. It has been estimated that 7.8% of the deaths from coronary disease are sudden and unexpected.[2] If we use this figure, approximately 40,000 sudden deaths occur annually in the U.S. from coronary artery disease. How many of these individuals are driving? In addition, not only are automobiles involved, but all motor vehicles—trains, boats and planes, private and commercial.

What can be done to help solve this problem of traffic safety and the cardiac patient? First, an accurate picture must be recorded of the number of drivers who die of natural causes at the wheel. If adequate post-mortem examinations are carried out for all drivers who die in accidents, such information might become available. The number who die of natural causes should be recorded and this information should be brought to the attention of the public, the medical profession and the driver licensing agencies. Legislation and regulation would then be more readily acceptable.

Secondly, physicians must accept the responsibility of advising their patients, who are drivers and have heart disease, about their fitness to drive. It is a well-known fact that persons who have had one coronary heart attack are more likely to have a second episode. Persons unfit to drive must be reported, and physicians must be more realistic with their advice.

Thirdly, legal requirements must be passed that require physicians to report to the state licensing agencies any patient who develops a medical condition which makes him a driving risk. Application blanks, both for initial licensing as well as for renewal, must ask the applicant if he has or has had heart disease.

The State of Washington refuses to issue drivers licenses to persons with heart disease when the condi-

tion has not been controlled for at least three months.[3] A special medical examination is required for any person with bradycardia or tachycardia. All other people with heart disease must submit to a regular physical examination. Deterioration, or an uncontrolled condition, usually results in a suspension of the drivers license. Such restrictions certainly are important if we are going to decrease the number of deaths by natural causes at the wheel.

In 1959, the Committee on Medical Aspects of Automobile Injuries and Deaths of the American Medical Association outlined physical standards for driver licensing, and for guidance of licensing authorities and physicians.[4] Their suggestions are briefly listed below:

1. Rheumatic fever. Any evidence of active rheumatic fever calls for marked restriction of activity, and such a patient should be advised not to drive.

2. Valvular disease. Appraisal must be made of the extent of the damage, the derangement of the rhythm, the progressive cardiac enlargement and the myocardial insufficiency. Obviously, significant aortic stenosis is prone to lead to sudden death and these patients should be advised not to operate a motor vehicle. Uncontrolled disease or deterioration is a definite indication for complete driving restriction.

3. Myocardial insufficiency. For whatever the reason, uncontrolled myocardial failure is an indication for the patient not to drive. A patient, with well controlled myocardial failure, however, may operate a private motor vehicle, but should not operate a commercial or passenger transport vehicle.

4. Disturbance of rhythm. Abnormal rhythm is a frequent complication of heart disease and these individuals may also drive private vehicles when well controlled, but should not be allowed to operate commercial or passenger vehicles.

5. Hypertensive heart disease. Hypertension itself is not disabling for the operation of a motor vehicle but the complications may well be. Therefore, restrictions are placed on the patient when congestive heart failure, angina pectoris or vision changes are discovered.

In general then, limitations are placed on those who have cardiac conditions which are uncontrolled or which may result in sudden death. Although rules, regulations, and restrictions must be made and enforced, at the present time, the physician still plays the major role in advising his patients about their fitness to drive, and in supporting legislation to make reportable, to the Department of Motor Vehicles, all persons unfit to have a license.

A list of references will be supplied upon request.

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected
for possible growth of principal and income.

NO SALES CHARGE
NO REDEMPTION CHARGE

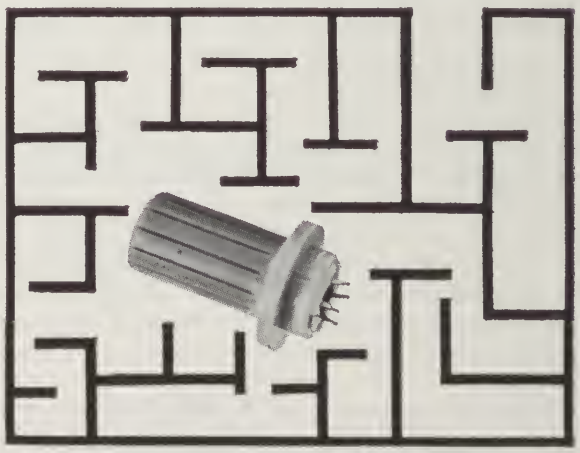
Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9

Report on Joint Meeting of the State Medical Society Representatives, State Hospital Association Representatives and the Standards Committee of the Joint Commission on Accreditation of Hospitals

The Joint Commission on the Accreditation of Hospitals was established in 1918 for the purpose of setting up standards which hospitals would have to meet in order to become accredited institutions. Since 1918, these standards have remained unchanged. A provisional draft of a revised list of standards was presented to the AMA House of Delegates in June, 1968, which, in turn, passed a resolution requesting that the draft be reviewed by state medical societies and state hospital associations before a final draft was drawn up and enacted.

On February 10, 11, and March 20, 21, 1969, representatives from the state medical societies and hospital associations met with the Standards Committee of the Joint Commission to review the provisional draft and make recommendations. Representatives from the Medical and Chirurgical Faculty were Richard D. Bauer, MD, and Manning W. Alden, MD. Their report is as follows:

Richard Palmer, MD, chairman of the Standards Committee, conducted the meetings and stated at the outset that any recommendations made by the representatives would be reviewed by the Joint Commission, but that the decision as to which recommendations would be incorporated in the final draft would be the sole responsibility of the Commission.

Dr. Palmer explained that the final draft would be presented in two books. Book 1 will contain information regarding accreditation of the hospital itself, ie, requirements as to dietetic services, emergency services, governing body and management, medical staff, medical records, etc. Book 2 will be a more detailed volume dealing with professional aspects of the various divisions of the modern hospital. Book 2, at this time, is in the process of being outlined. This also will be presented for review by hospital and medical society representatives.

Approximately 160 people attended the meetings which were in the form of informal discussions. The sections of the draft covered included dietetic services, emergency services, governing body and management, library services, medical records department, medical staff, nursing staff, pathology, pharmacy, physical therapy services, radiology, and safety.

One of the main points discussed was the establishment of multidisciplinary committees. The provisional draft calls for these committees to be designated by the governing body. Physician representatives at the meeting emphatically stated that this should be under the province of the medical staff, particularly in regard to medically oriented committees having to do with records, utilization, pharmacy and therapeutic analysis, infection control, tissue committee, etc. (All physicians were requested to discuss this with their AMA delegates.)

Another controversial item centered on physician representation on hospital boards of governors. Some hospitals ban physicians from serving in this capacity, and the Standard Committee feels physicians should participate on such boards. Certain members of the Hospital Association argued that no physician should serve in this capacity. They also stated that the president of the staff should not even sit at board meetings in an *ex officio* capacity, with or without a vote. In all fairness, it must be said that some Association members didn't go this far, but in general, the two groups were at odds. The physicians felt that there should be no prohibition of this function and privilege.

In essence, your representatives' opinion was that, since the physician is the *most important single working entity in any hospital,* since hospitals have functioned in the course of history without governing boards, without lay administration, without gas or electricity, sometimes without even nurses, *but never without doctors,* it should be mandatory that physicians be adequately represented on governing boards—not *ex officio*—but right in the middle of that board, with a vote. It was pointed out that less stress should be put on specified meetings of the sterile organization called a Joint Conference Committee, which in many instances exists as a "sop" to the doctors and which would be far less necessary if physicians sat on the board in the first place, making the Joint Conference Committee a sort of *ad hoc* organization which would only meet for specific purposes when needed. This, in turn would cut down on the volume of meetings one had to attend.

The section on nursing seemed to most of us to

concentrate on the administrative aspects of nursing care and we asked that it be rewritten to give the impression, at least, that the nurse's prime duty was patient care, and the paper-work aspect, though necessary, should be secondary.

In regard to the section on Pathology, Dr. Alden asked that the Chief Principle be changed to read: "The hospital shall *assure the availability* of pathological facilities and services adequate to meet the needs of the patient." He would like the Faculty to send in a written request that this be changed.

It was pointed out that hospital laboratories are subject to the constant evaluations of the American Board of Clinical Pathologists and the American Association of Blood Banks. Laboratories that are certified by these groups should have no fear of examination by the JCAH. It was felt, also, that clinical departments in general, which were certified for intern and residency training, are likewise a step ahead. This is one of the reasons the format of JCAH evaluations is being changed.

It is of interest to note that the Joint Commission on Accreditation recognizes that the procedure followed in reviewing a hospital for accreditation has had certain deficiencies. It is hoped that these deficiencies will be corrected in the near future. For instance, it is proposed that once the new standards are adopted, the Joint Commission will send as many as three representatives to a single hospital and these representatives may spend from one to three or more days with that institution going over its various divisions in minutia. The time allotted to each institution and the number of persons visiting that institution will, of course, be governed by the complexity and size of the institution. It was also announced that, prior to the time of inspecting the hospital for new accreditation or re-accreditation, the state medical society in that state would be advised far enough in advance so that they could provide the Joint Commission with information on particularly troublesome areas in that hospital.

As referred to above, the greatest amount of discussion of the standards tended to center around the question of (1) due process and (2) the presence of physicians as voting members on the governing board of a hospital. The summation of the discussion on due process, in effect, established that the Joint Commission will require, as a part of the bylaws of a medical staff, the opportunity for a physician to have a hearing in the event privileges to practice in a given institution are denied, or in the event privileges previously granted are reduced or removed at any time. Secondly, the Joint Commission will probably include in the new regulations a requirement that there be no restriction to physician staff members serving as voting members of a hospital board.

M.D.'s
or
DENTISTS
in
ASSOCIATED
PRACTICE

Up to 8,000 sq. ft. of office space, custom-finished to your specifications. Prime northwest Baltimore location. 2 min. from Sinai Hospital, Jones Falls Expwy. Ample parking space. Jitney service to nearby bus stops. Special tax advantages for resident doctors. Leasing and Management, Chas. H. Steffey, Inc. Call 685-2412 or 542-6684



NORTHERN PARKWAY AT JONES FALLS EXPRESSWAY



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

What Kinds of Questions is a Medical Reference Library Asked?

Questions coming into our library are varied, interesting, technical, and occasionally absurd. However, we make every effort that we, as librarians, not physicians, are capable of, or that we consider to be within our province. Often, a perturbed patient calls the library to find out whether a drug prescribed by his physician may be causing adverse reactions. Others call in hopes of finding a diagnosis of their conditions without the need for consulting a physician.

Diagnosticians librarians are not, so we kindly remind callers that they will need to see their own physician, or that we will assist them in locating a general practitioner, or specialist, as the need demands. Many want a "rating" on physicians and register surprise when the librarian informs them we have no such "rate book". Another type of question comes in this form: "Who is the best ear man, or heart specialist, or hand surgeon?" Aside from these oft-repeated questions, though, others of interest received in the last four months have included:

Who are physicians using hypnotism in psychiatry? Obstetrics? For treatment of obesity?

Hair transplants—is it safe? Who performs transplants in Baltimore?

Can you describe the duties of a medical director in a hospital?

Can you furnish the name of a heart specialist in Taipei?

Can a naturopath practice in Maryland?

Know a German-speaking psychiatrist in Baltimore?

Suggest a physician specializing in Hodgkin's Disease?

Have you pictures of old quarantine signs?

Where can I offer myself for research on the reappearance of mouth ulcers periodically?

What birth control methods are used in foreign countries?

Dates of Dr. Henning Waldenström, Swedish physician? (This was found through the Swedish embassy via cable to Stockholm.)

Name of the organization(s) experimenting with freezing bodies (cryonics)?

Will you refer me to obesity clinics in Baltimore?

American-trained doctors practicing in Munich?

What does 89 mean in diabetes diagnosis?

What substitutions can be made in a baby's diet?

Do you have records showing names of *all* physicians practicing in Maryland since its beginning?

Can you send a sample of an agreement to share offices?

Do you have a book on illnesses of U.S. presidents and information about their physicians?

Please suggest a psychiatrist interested in literature, mainly novels and poetry?

Do you know of a beautiful female psychologist I could consult? I might as well see some beauty if I have to spend my money this way! (No, we couldn't; at least not in Baltimore. If you know one, let the library know please.)

(The above questions were selected from a daily record of telephone requests.)

Growing Feet Can Have Problems!



PRONATION KNOCK-KNEES PIGEON-TOES

These common problems can be helped with proper shoes, correctly fitted.

Prescriptions Carefully Filled

VAN DYKE & BACON

307 N. Charles St. SAratoga 7-3775
5849 York Rd. IDlewood 3-1100
Baltimore, Maryland

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.

Miss Gladys Deeds
Manager

213 West Saratoga St. 727-7011

—The lowest priced tetracycline—nystatin combination available—



MINUTES

First Meeting, 171st Annual Session, House of Delegates
(264th Meeting)
Medical and Chirurgical Faculty of the State of Maryland
Wednesday, April 9, 1969
The Alcazar, Baltimore, Maryland

The 264th meeting, first of the 171st Annual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:40 a.m., Wednesday, April 9, 1969, at The Alcazar, Baltimore, Maryland, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Robert T. Adkins, Wicomico County
Manning W. Alden, Council
Timothy D. Baker, Baltimore city
John G. Ball, Council
James W. Banks, Washington County
Richard D. Bauer, Past President
Francis J. Borges, Baltimore city
M. McKendree Boyer, Past President
Henry A. Briele, Council
*G. Cader, Baltimore city
Douglas Gordon Carroll, Baltimore city
Katharine A. Chapman, Montgomery County
John T. Chissell, Council
John N. Classen, Baltimore city
Shirley R. Clinton, Baltimore city
Archie R. Cohen, Council
Kenneth Cruze, Montgomery County
William B. Culwell, Carroll County
*Luis M. Cuza, Cecil County
Worth B. Daniels, Jr., Baltimore city
Melvin B. Davis, Baltimore County
John B. De Hoff, Baltimore city
DeWitt E. DeLawter, Montgomery County
John M. Dennis, Council
*Michael Dobridge, Montgomery County
J. Sheldon Eastland, Past President
Wm. Carl Ebeling, Council
Wolcott L. Etienne, Council
James McC. Finney, Harford County
Vincent J. Fiocco, Carroll County
Whitmer B. Firor, Past President
Russell S. Fisher, Council
*Abraham Genecin, Baltimore city
*Robert B. Goldstein, Baltimore city
Edward G. Grau, Baltimore County
Paul F. Guerin, Council
William B. Hagan, Council
Louis E. Harmon, Baltimore city
John Collins Harvey, Council
Wm. G. Helfrich, Baltimore city
Thomas F. Herbert, Howard County
Philip W. Heuman, Harford County
Claude D. Hill, Baltimore city
H. Logan Holtgrewe, Anne Arundel County
J. Parran Jarboe, Council
Page C. Jett, Calvert County
Frederick M. Johnson, Charles County
Ferd E. Kadan, Baltimore city
James R. Karns, Baltimore city
Arthur T. Keefe, Jr., Council
Robert C. Kimberly, Council
Seruch T. Kimble, Council
Howard F. Kinnamon, Past President
Edward L. J. Krieg, Baltimore County
Santiago Laurel, St. Mary's County
Henry P. Laughlin, Council
C. Rodney Layton, Queen Anne's County
Herbert H. Leighton, Garrett County
*L. Levitsky, Prince Georges County
Charles H. Ligon, Montgomery County
Eugene Linberg, Baltimore city
Charles B. Marek, Baltimore city
Francis C. Mayle, Montgomery County
Karl F. Mech, Council
B. Martin Middleton, Council
John E. Miller, Baltimore city
Donald W. Mintzer, Baltimore city
Frederick E. Musser, Prince Georges County
Sidney Novenstein, Washington County
Chas. F. O'Donnell, Past President
William A. Pillsbury, Jr., Council
*H. Plummer, Caroline County
C. G. Rawley, Somerset County
*Belden R. Reap, Montgomery County
J. Morris Reese, Council
Guy M. Reeser, Jr., Talbot County
Harry G. Reeves, Wicomico County
William F. Renner, Baltimore city
Peter W. Rieckert, Dorchester County
Martin A. Robbins, Baltimore city
*James A. Roberts, Montgomery County
Raymond C. V. Robinson, Baltimore city
Donald J. Roop, Council
Harry Paul Ross, Kent County
Salvador Rossello, Baltimore city
Edwin Ruzicka, Talbot County
John F. Schaefer, Council
John O. Sharrett, Baltimore city
George Simons, Allegany County
Arthur G. Siwinski, Council
R. Kennedy Skipton, Prince Georges County
Gordon M. Smith, Montgomery County
Roland T. Smoot, Baltimore city
Aaron C. Sollod, Baltimore city
Wm. G. Speed, III, Council
George R. Spence, Montgomery County

Andrew Stasko, Allegany County
*S. Jack. Sugar, Prince Georges County
Francis J. Townsend, Jr., Worcester County
John B. Umhau, Montgomery County
Thomas E. Van Metre, Jr., Baltimore city
Emerson C. Walden, Baltimore city
J. Arthur Weinberg, Council
Wm. C. Weintraub, Prince Georges County
Lawrence R. Wharton, Jr., Baltimore city
Chas. H. Williams, Baltimore County
John G. Wiswell, Baltimore city
Charles E. Wright, Frederick County
*N. Louise Young, Baltimore city
Raymond M. Yow, Council

Present also were staff personnel.

INVOCATION

Mr. Arne Larson, Assistant Director, Department of Medicine and Religion, American Medical Association, delivered the invocation.

ANNOUNCEMENTS

The President made certain announcements with regard to the conduct of business at the session.

MINUTES

The minutes of the House of Delegates of September 5 and 6, 1968 semiannual session, having been distributed to the members and having been approved by the Executive Committee, were presented to the House for information.

INTRODUCTION OF GUESTS

The President introduced Richard W. Corbitt, MD, President of the West Virginia State Medical Association, who spoke briefly to the House.

NECROLOGY

After the Secretary read the following names of deceased members, the members of the House of Delegates rose in observance of a moment's silence in respect for their deceased colleagues:

Anne Arundel County

Abramson, David L.	May 25, 1968
Benedict, Ludwig	May 13, 1968
Faubert, Gustav H.	September 10, 1968
Sheehan, Joseph C.	March 23, 1969

Baltimore city

Bawden, George A.	June 20, 1968
Bernstein, Alan	February 24, 1969
Bix, Harold H.	December 23, 1968
Cohn, Clarence L.	May 26, 1968
Cox, William F., III	November 5, 1968
Cross, Ernest S., Sr.	May 5, 1968
Edmonds, Charles W.	November 18, 1968
Fort, Wetherbee	December 27, 1968
Kane, Harry F.	December 5, 1968
Kern, M. Howard, Sr.	October 4, 1968
Kirkman, Walter N.	July 8, 1968
Loker, F. Ford	October 4, 1968
Parsons, John W.	April 20, 1968
Rosenfeld, Morris	February 17, 1968
Rutledge, Benjamin H.	July 22, 1968
Scarborough, C. Parke	June 4, 1968
Schwartz, Theodore A.	June 1, 1968
Shoemaker, Norman C.	October 9, 1968
Todd, Homer U.	March 1, 1969
Whedbee, James S., Sr.	October 25, 1968
Wise, Walter D.	July 23, 1968
Ullman, Alfred	January 9, 1969

Baltimore County

Farley, Francis E.	November 26, 1968
Hetherington, Leon H.	February 9, 1969
Holden, F. A.	March 18, 1968
Magness, Stephen L.	November 4, 1968
Medairy, George C.	November 21, 1968
Sanner, J. Everett	October 17, 1968

Kent County

Eglitis, Rudolfs	February 2, 1969

Montgomery County

Allen, Samuel	July 1, 1968
Gill, Grover B.	August 18, 1968
Queen, G. Burton	September 7, 1968
Masur, Jack	March 8, 1969

Prince Georges County

Brainin, William	December 10, 1968
Clements, William H.	November 3, 1968
Malin, Wendell E., Jr.	June 20, 1968

Somerset County

Collins, Clarence E.	August 9, 1968

Talbot County

Winters, William L.	August 9, 1968

Washington County

Whitcomb, David T.	March 28, 1968

Affiliates

Heinbach, Anne B.	
Quitasol, Zoilo, A., Jr.	March 28, 1968

SPECIAL RECOGNITION OF DECEASED MEMBER

Russell S. Fisher, MD, President-Elect, offered the following resolution in memory of a distinguished member who had died during the previous year, which was adopted unanimously.

WETHERBEE FORT, MD 1895-1968

Whereas, Wetherbee Fort, MD, died on Friday, December 27, 1968; and

Whereas, As the son of a distinguished physician, he was an outstanding example of an individual who expressed compassion, understanding and concern for his patients; and

Whereas, His devotion to the profession and its ideals did not stop there, but carried over into the activities of the Medical and Chirurgical Faculty of the State of Maryland, as well as in the Baltimore City Medical Society; and

Whereas, He served in many offices at a local, state and national level; and

Whereas, His enthusiasm, his energy and his judgment did much to improve the position of the Faculty; and

Whereas, His ability and industry brought financial soundness and integrity to the operations of the Medical and Chirurgical Faculty; and

Whereas, His distinguished record of accomplishments, his rare qualities of mind and heart, his devotion to the profession endeared him to all, be it therefore

Resolved, That this resolution be spread upon the minutes of the Medical and Chirurgical Faculty's House of Delegates session on Wednesday, April 9, 1969; and be it further

Resolved, That a copy of this resolution be sent to the relatives of Wetherbee Fort, MD, with the notation that this recognition of his efforts on behalf of the Faculty are in this small way hereby acknowledged.

RESOLUTION HONORING DEAN WILLIAM S. STONE ON HIS RETIREMENT

Russell S. Fisher, MD, President-Elect, presented the following resolution honoring Dean William S. Stone, MD, of the University of Maryland School of Medicine, on the occasion of his retirement as Dean, which was adopted unanimously:

Whereas, The year 1969 will see the retirement of William S. Stone, MD as Dean, University of Maryland School of Medicine, and

Whereas, Dean Stone served as Director of Medical Education and Research at the University of Maryland School of Medicine from 1950 to 1954, and Dean from 1954 to 1969, and

Whereas, During this period of time he has brought the educational standards of the School of Medicine to its present high state, and

Whereas, Previous to assuming these responsibilities he served with distinction and honor in the United States Armed Forces from 1929 through 1954, a long and distinguished career; and

Whereas, Dean Stone has gained the respect, admiration and regard of all his colleagues, locally, state-wide and at a national level, and

Whereas, During this period of time he has brought pride and distinction to the University of Maryland School of Medicine, and

Whereas, a person having such distinction and being held in such high regard should receive the honors and credits as his just due, and

Whereas, This House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland wishes to recognize the outstanding ability of Dean Stone, be it

Resolved, That this House of Delegates give a standing ovation to William Spencer Stone, MD, in recognition of its respect and regard for him, and be it

Resolved, That a copy of this Resolution be spread upon the minutes of this session of the House of Delegates, and be it

Resolved, That this be prepared as a suitably engraved scroll and presented to him as a tribute on the occasion of his retirement as Dean of the University of Maryland School of Medicine.

AWARD OF VIET NAM PLAQUES

The President awarded plaques for voluntary service in Viet Nam under the AMA's program of Volunteer Physicians For Viet Nam to the following:

Andre Fesus, MD, Baltimore
Thomas H. Powell, MD, Baltimore
Glendon E. Rayson, MD, Baltimore
Donald K. Wallace, MD, Baltimore
Celeste L. Woodward, MD, Baltimore

PRESENTATION OF FIFTY-YEAR PINS

The President awarded Fifty-Year pins to the following members who were present for the meeting:

Baltimore city:	John A. Buchness, MD
	Robert W. Johnson, Jr., MD
	Charles Reifschneider, MD

Other physicians completing fifty years of Faculty membership but who could not be present were:

Baltimore city:	I. B. Bronushas, MD
	Henry F. Buettner, MD
	Milton H. Cumin, MD
	Louis Krause, MD
	Harry L. Rogers, MD
	D. C. Wharton Smith, MD
	W. Houston Toulson, MD
Baltimore County:	Dawson L. Farber, MD
	H. Lawrence Wheeler, MD
Howard County:	B. Bruce Brumbaugh, MD
Montgomery County:	F. J. Broschart, MD
	Gilbert V. Hartley, MD

EMERITUS MEMBERSHIP

On motion of the Chairman of the Council, John F. Schaefer, MD, the following members who had received the recommendation of their respective societies and the Council, were elected to Emeritus Membership in the Faculty:

Baltimore city:	H. F. Bongardt, MD
	S. DeMarco, MD
	Jacob R. Jensen, MD
	Leo Kanner, MD
	C. W. Peake, MD
Carroll County:	Elizabeth Reese Wilkens, MD
Montgomery County:	John N. Andrews, MD
Washington County:	J. Walter Layman, MD
	Lester M. Shaffer, MD

RESOLUTION 6A/68 CONTINUING ITEM ON HOUSE AGENDA

Dr. Schaefer, Council Chairman, reported that discussions were proceeding with representatives of the Governor's office in connection with Resolution 6A/68, which is to be carried as a continuing item on House of Delegates agendas until the problems in connection with the Medicaid program are resolved. No concrete recommendations are made at this time and a further report

will be made at the Semiannual session.

HONORARY MEMBERSHIP

On motion of Dr. Schaefer, the Chairman of the Council, the following member who had received the recommendation of her constituent society and the council was elected by the required ⅔ vote to Honorary Membership in the Faculty:

Talbot County: Jessie Wright, MD

DISBANDMENT OF PL 89-97 LIAISON SUBCOMMITTEE

On behalf of the Council, Dr. Schaefer, Council Chairman, moved "That the PL 89-97 Liaison Subcommittee be disbanded," which was adopted unanimously.

TREASURER'S REPORT

The Treasurer then presented the 1969 budget for the information of the House, this having been adopted by the Council. The Treasurer then presented the following motion which was unanimously adopted by the House:

> That the MEDIC Network be continued and that sufficient funds be appropriated to the extent needed to finance the operations for the coming MEDIC year.

PRESENTATION OF AMERF CHECKS

The President then presented checks representing voluntary contributions made by Maryland physicians to the American Medical Education and Research Foundation. Henry Siedel, MD, accepted the check for $8,737.11 presented to The Johns Hopkins University School of Medicine; and Dean William S. Stone, MD, accepted the check for $13,550.53 on behalf of the University of Maryland School of Medicine. Appreciation and thanks were expressed by the representatives of the recipients.

PRESENTATION OF PLAQUE TO DEAN WILLIAM S. STONE

The President then presented a plaque honoring Dean William S. Stone, on his retirement as Dean of the University of Maryland School of Medicine.

POLICY AND PLANNING COMMITTEE REPORT

Arthur T. Keefe, Jr., MD, Chairman of the Policy and Planning Committee, on behalf of his Committee moved adoption of his Committee recommendations, which, after discussion and amendment were recommitted to the Policy Planning Committee, together with a pending amendment, for clarification, by a division vote of 43 in the affirmative and 31 in the negative. The recommendations and the pending amendment read as follows:

1. The function of utilization review in Extended Care Facilities should be administered on the local county or regional (group of adjacent counties) level. The Medical and Chirurgical Faculty's role should be one of information and guidance.
2. A committee of the Faculty (already existing or newly appointed if necessary) should be charged with gathering information concerning utilization review from all available sources and stimulating formation of local or regional review committees. This information, along with administrative suggestions should be available to any component societies requesting such.
3. That the Medical and Chirurgical Faculty endorse, as Faculty policy, the principal of utilization review in all Nursing Home Facilities in addition to that required under State and Federal regulations as a means of assuring quality medical care for the patients in such nursing homes.

For the purpose of this recommendation, it is the intention of the Medical and Chirurgical Faculty to be primarily concerned in upgrading the quality of medical care in these facilities.

(Pending amendment underlined)

Definitions of the three types of nursing homes are as follows:

Nursing Home—Extended Care means any institution which renders skilled nursing care to persons suffering from disease or other disabilities. (Skilled nursing care includes care rendered by registered professional nurse or licensed practical nurse under the supervision of a registered nurse.)

Nursing Home—Long Term Care means rendering nursing care (by or under supervision of an RN or a LPN to persons suffering from disease or other disabilities.)

Personal Care Home means any institution which renders personal care (services which an individual would normally perform for himself but for which he is personally dependent on others because of advanced age, infirmity, physical or mental limitations).

BYLAWS COMMITTEE REPORT

Charles F. O'Donnell, MD, Chairman of the Bylaws Committee, on its behalf, moved the adoption of the following bylaw amendments which, after debate, were adopted in each case by more than the required two-thirds vote.

Amend Article XI, by inserting new section 13 to read as follows:

> Section 13. A Committee on Medicine and Religion shall be appointed by the President to consist of not less than six members. It shall be charged with maintaining liaison and effective lines of communication between physicians and clergymen leading to the most effective care and treatment of the patient and his family. It shall also endeavor to assist medical schools and nursing schools in their educational endeavors, and shall be available to theological seminaries for similar assistance—all within the areas of medicine and religion combined.

Amend Article VII, Section 2, by striking out the following:

"authorize physicians' defense"

Amend Article XII, Section 1, by striking out:

"to the Council"

Amend Article XII, Section 2, by striking out:

"On a majority vote, the Council may authorize physicians' defense and the matter"

and inserting:

"Physicians' Defense Cases"

Amend Article II, Section 5, by adding the following new sentence:

"Forty-Year Members who have this status prior to removing from the State of Maryland may continue to hold this type of membership after their removal."

Charles F. O'Donnell, MD, Chairman of the Bylaws Committee, on its behalf, moved the adoption of the following Bylaw amendment which, after debate and a proposed amendment, was recommitted to the Bylaws Committee together with a pending amendment for further study and report.

Substitute for Article IV, Section 3, the following new section which reads as follows:

Section 3. One third of the COUNCILORS provided below shall be elected annually by the House of Delegates from among the active members of component societies comprising the following districts:

(a) Western District: Allegany, Garrett, Carroll, Frederick, and Washington counties

(b) Eastern District: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico, and Worcester counties

(c) Central District: Baltimore city, Baltimore and Harford counties

(d) Southern District: Anne Arundel, Calvert, Charles, Howard, and St. Mary's counties

(e) South Central District: Montgomery and Prince George's counties

Representation shall be on the basis of one Councilor from each district, plus one additional councilor for each 200 active and 40-year members in good standing on December 31 each year.

The pending amendment read as follows:

Amend the proposed substitute for Article IV, Section 3, by adding to the final paragraph:

A component society in the central and south-central districts shall be entitled to be represented on the Council as nearly as may be possible by one councilor for each 200 active and 40-year members in good standing of such component society on December 31 of each year.

NOMINATING COMMITTEE REPORT

Richard D. Bauer, MD, Nominating Committee Chairman, presented the following slate:

President-elect (President-elect 1969-70)
Henry A. Briele, Salisbury (President 1970-71)

First Vice-President
John F. Schaefer, Baltimore

Second Vice-President
Charles H. Ligon, Sandy Spring

Third Vice-President
Daniel I. Welliver, Westminster

Secretary
William A. Pillsbury, Timonium

Treasurer
Karl F. Mech, Baltimore

Councilors
Robert B. Goldstein, Baltimore, Central District (1973)
Henry P. Laughlin, Bethesda, South Central (1973)
D. Frank Kaltreider, Baltimore, Central (1973)
John C. Harvey, Baltimore, Central (1973)
Arthur T. Keefe, Jr., Chestertown, Eastern (1973)
William G. Speed, III, Baltimore, Central (1973)
Philip F. Wagley, Baltimore, Central (1973)

Delegate to American Medical Association
Russell S. Fisher, Baltimore
(Jan. 1, 1970—Dec. 31, 1972)

Alternate Delegate to American Medical Association
M. McKendree Boyer, Damascus
(Jan. 1, 1970—Dec. 31, 1972)

Committee on Program and Arrangements:
Julius R. Krevans, Baltimore (1974)

Library and History Committee
Paul F. Guerin, Baltimore (1975)

Finney Fund Committee
Thomas G. Edison, Silver Spring (1975)

Board of Medical Examiners
J. Roy Guyther, Mechanicsville (June 1969—June 1971)
John E. Adams, Towson (June 1969—June 1973)
DeWitt E. DeLawter, Bethesda (June 1969—June 1973)

The floor was opened to further nominations for these offices and there being none, nominations were closed by general consent, the election to be held at the second meeting of the session, Friday, April 11, 1969, at the Faculty building. The nominees for the Board of Medical Examiners are to be elected at the General Session, Thursday, 12:00 Noon, April 10, 1969, at The Alcazar.

INFORMATION COMMITTEE REPORTS

The following reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions:

Report of the Delegates to the American Medical Association—Robert vL. Campbell, MD, J. Sheldon Eastland, MD, Russell S. Fisher, MD, December 1968, Clinical Meeting

Secretary—William A. Pillsbury, MD

Executive Secretary—Mr. John Sargeant

Library and History Committee and Finney Fund Committee—Paul F. Guerin, MD, and D. C. W. Finney, MD

Curator—Edwin David Weinberg, MD

Medical Annals—Leslie E. Daugherty, MD

Committee on Program and Arrangements—Joseph D. B. King, MD

Committee on Contractual Arrangements—J. Howard Franz, MD

Editorial Board, Maryland State Medical Journal—C. Thomas Flotte, MD, Editor

Committee on Emotional Health—Thurman Mott, MD

Finance Committee—Karl F. Mech, MD

Maryland Medical Service, Board of Trustees— J. Sheldon Eastland, MD, President

Med-Chi Insurance Trust—Paul F. Guerin, MD

Medical Emergency Disaster Service Committee—John W. Ashworth, MD

Committee on Postgraduate Education, Preventive Medicine and Public Health—John Whitridge, MD
Membership Committee—William G. Helfrich, MD
Public Relations Committee—Richard A. Young, MD

NOTE: Reports of the following Committees will be presented to the Semiannual Meeting for information and action at that time:

(a) Board of Medical Examiners
(b) Medical Economics Committee
(c) Legislative Committee
(d) Liaison Committee
(e) Mediation Committee
(f) Medicolegal Committee
(g) Occupational Health Committee
(h) Professional Medical Services Committee
(i) Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program
(j) Auditor's statement for 1968

ANNOUNCEMENTS

The President made certain announcements concerning meetings scheduled during the annual session.

The meeting was adjourned at 11:05 A.M., until 2:00 P.M. Friday, April 11, 1969, at the Faculty Building.

WILLIAM A. PILLSBURY, MD, *Secretary*

Election of the Board of Medical Examiners

A general meeting of the Medical and Chirurgical Faculty of the State of Maryland was held on Thursday, April 10, 1969, at 12 Noon, at the Alcazar, Cathedral and Madison Streets, Baltimore, Maryland, 21201, for the purpose of electing members of the Board of Medical Examiners as follows:

one, for a two-year term
two, for a four-year term

The President, Arthur G. Siwinski, MD, presided and called the meeting to order at 12:14 P.M.

The names of the nominees for the posts shown were presented to the General Meeting as follows:

J. Roy Guyther, MD, Mechanicsville—for two-year term commencing June 1, 1969

John E. Adams, MD, Towson
DeWitt E. DeLawter, MD, Bethesda } —for 4-year term commencing June 1, 1969

Nominations from the floor were requested. There being none, the President declared nominations closed.

Election took place by acclamation and the Secretary, William A. Pillsbury, MD, was instructed to cast one ballot for those nominated.

There being no further business, the meeting adjourned at 12:16 P.M.

WILLIAM A. PILLSBURY, M.D., *Secretary*

Second Meeting, 171st Annual Session, House of Delegates
(265th Meeting)
Medical and Chirurgical Faculty of the State of Maryland
Friday, April 11, 1969
Faculty Building, Baltimore, Maryland

The 265th meeting, second of the 171st Annual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was held at the Faculty Building, 1211 Cathedral St., Baltimore, Maryland, at 2:00 p.m. on Friday, April 11, 1969, the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate:

Robert T. Adkins, Wicomico County
Manning W. Alden, Council
Timothy D. Baker, Baltimore city
John G. Ball, Council
Richard D. Bauer, Past President
*Norman K. Bohrer, Prince Georges County
Francis J. Borges, Baltimore city
M. McKendree Boyer, Past President
Henry A. Briele, Council
*G. Cader, Baltimore city
Robert vL. Campbell, Past President
Douglas Gordon Carroll, Baltimore city
Katherine A. Chapman, Montgomery County
John T. Chissell, Council
John N. Classen, Baltimore city
Archie R. Cohen, Council
Kenneth Cruze, Montgomery County
William B. Culwell, Carroll County
Worth B. Daniels, Jr., Baltimore city
Melvin B. Davis, Baltimore County
John B. De Hoff, Baltimore city
*D. H. Dembo, Baltimore city
DeWitt E. DeLawter, Montgomery County
John M. Dennis, Council
J. Sheldon Eastland, Past President
James McC. Finney, Harford County
Vincent J. Fiocco, Carroll County
Whitmer B. Firor, Past President
Russell S. Fisher, Council
*Abraham Genecin, Baltimore city
*William E. Gilmore, Baltimore city
Gina M. Glick, Allegany County
Marvin Goldstein, Baltimore city
*Robert B. Goldstein, Baltimore city
Paul F. Guerin, Council
William B. Hagan, Council
John Collins Harvey, Council
Wm. G. Helfrich, Baltimore city

Thomas F. Herbert, Howard County
William A. Holbrook, Jr., Prince Georges County
J. Parran Jarboe, Council
Ferd E. Kadan, Baltimore city
James R. Karns, Baltimore city
Arthur T. Keefe, Jr., Council
Robert C. Kimberly, Council
Seruch T. Kimble, Council
Edward L. J. Krieg, Baltimore County
Herbert H. Leighton, Garrett County
*L. Levitsky, Prince Georges County
Charles H. Ligon, Montgomery County
Elmer G. Linhardt, St.Bd. of Med.Exam.
William E. McGrath, Baltimore County
Clarence E. McWilliams, Baltimore County
Karl F. Mech, Council
B. Martin Middleton, Council
John E. Miller, Baltimore city
Donald W. Mintzer, Baltimore city
*Howard T. Morse, Montgomery County
Sidney Novenstein, Washington County
Chas. F. O'Donnell, Council
Hilary T. O'Herlihy, Anne Arundel County
A. Austin Pearre, Past President
William A. Pillsbury, Council
Carolyn S. Pincock, Montgomery County
Guy M. Reeser, Jr., Talbot County
Harry G. Reeves, Wicomico County
Thomas Reid, Frederick County
William F. Renner, Baltimore city
Peter W. Rieckert, Dorchester County
Raymond C. V. Robinson, Baltimore city
Donald J. Roop, Council
Harry Paul Ross, Kent County
Salvador Rossello, Baltimore city
Peter A. Santucci, Montgomery County
John F. Schaefer, Council
Arthur G. Siwinski, Council
R. Kennedy Skipton, Prince Georges County
Gordon M. Smith, Montgomery County
Roland T. Smoot, Baltimore city
Aaron C. Sollod, Baltimore city
Wm. G. Speed, III, Council
George R. Spence, Montgomery County
Martin E. Strobel, Baltimore County
Francis J. Townsend, Jr., Worcester County
John B. Umhau, Montgomery County
Thomas E. Van Metre, Jr., Baltimore city
*S. J. Venable, Jr., Baltimore County
Emerson C. Walden, Baltimore city
Wm. C. Weintraub, Prince Georges County
Lawrence R. Wharton, Jr., Baltimore city
Chas. H. Williams, Baltimore County
John G. Wiswell, Baltimore city
Charles E. Wright, Frederick County
*N. Louise Young, Baltimore city
Raymond M. Yow, Council

Present also for the meeting were staff personnel.

INVOCATION

Donald W. Mintzer, MD, gave the invocation.

ELECTION OF OFFICERS

There being no candidates from the floor and there being only one candidate for each of the positions to be filled, by unanimous consent the ballot was dispensed with. The following were then elected by voice vote:

President-elect (President-elect 1969-70)
Henry A. Briele, Salisbury (President 1970-71)
First Vice-President
John F. Schaefer, Baltimore
Second Vice-President
Charles H. Ligon, Sandy Spring
Third Vice-President
Daniel I. Welliver, Westminster
Secretary
William A. Pillsbury, Timonium
Treasurer
Karl F. Mech, Baltimore
Councilors
Robert B. Goldstein, Baltimore, Central District (1973)
Henry P. Laughlin, Bethesda, South Central (1973)
D. Frank Kaltreider, Baltimore, Central (1973)
John C. Harvey, Baltimore, Central (1973)
Arthur T. Keefe, Jr., Chestertown, Eastern (1973)
William G. Speed, III, Baltimore, Central (1973)
Philip F. Wagley, Baltimore, Central (1973)
Delegate to American Medical Association
Russell S. Fisher, Baltimore
(Jan. 1, 1970—Dec. 31, 1972)
Alternate Delegate to American Medical Association
M. McKendree Boyer, Damascus
(Jan. 1, 1970—Dec. 31, 1972)
Committee on Program and Arrangements:
Julius R. Krevans, Baltimore (1974)
Library and History Committee
Paul F. Guerin, Baltimore (1975)
Finney Fund Committee
Thomas G. Edison, Silver Spring (1975)

BOARD OF MEDICAL EXAMINERS ELECTION

The President advised the House that members of the Board of Medical Examiners had been elected in a General Session held on Thursday, April 10, 1969, as follows:

J. Roy Guyther, MD, Mechanicsville, 1969-71
John E. Adams, MD, Towson, 1969-73
DeWitt E. DeLawter, MD, Bethesda, 1969-73

PRESENTATION OF SCROLL TO J.G.F. SMITH, MD

Russell S. Fisher, MD, President-elect, presented a scroll to J. G. F. Smith, MD, of Brunswick, Md., honoring him for 53 years of service to the community.

INTRODUCTION OF GUESTS

The President introduced the following guests of the Faculty, both of whom spoke briefly on behalf of the medical societies they represented:

John F. Kustrup, MD, President, Medical Society of New Jersey
G. E. Farrar, MD, President, Pennsylvania Medical Society

PRESIDENT OF WOMAN'S AUXILIARY

Mrs. H. Leonard Warres, President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland, requested

permission of the House to speak before it. There being no objection, permission was granted.
Mrs. Warres then read a report of the Auxiliary activities during the past year.

STUDENT AMA PRESIDENT

Mr. David Tapper, President, University of Maryland Chapter, Student American Medical Association, was granted the privilege of speaking to the House by unanimous consent. He reported on the activities of the Chapter during the past year.

MMPAC CHAIRMAN

George G. Finney, Jr., MD, Chairman, Maryland Medical Political Action Committee, spoke to the House, after being granted this privilege. He outlined the activity of the MMPAC Committee during the past year.

REFERENCE COMMITTEE REPORT

Herbert H. Leighton, MD, on behalf of the Reference Committee, presented its report and on behalf of the Committee, recommended that Resolution 1S/68, as amended, be adopted.

RESOLUTION 1S/68 ADOPTED AS AMENDED

The House adopted Resolution 1S/68, which, as amended, read as follows:

Whereas, The United States Government through its various health programs such as, Medicare (Title 18), the Federal Employees Health Insurance Program, and U. S. Armed Forces Dependents Medical Care Program, as well as many others, is based on the concept of payment to the physician of his Usual and Customary Fees; and

Whereas, The United Steel Workers of America has negotiated contracts with their employers that provide for provision of health insurance making payment to physicians on the basis of their Usual and Customary Fees; and

Whereas, The House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland on September 9, 1966, adopted a resolution in which the "resolved" portion reads as follows:

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record as urging its members to submit bills for payment of "usual, customary and reasonable fees" for professional services rendered Workmen's Compensation Cases, as well as other governmental agencies; and

Whereas, The present provisions of the Workmen's Compensation Law, Article 101, Section 37(c) reads as follows:

"All fees and other charges for such treatment and services shall be subject to regulation by the Com-
* mission, and shall be *limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living.*" and

* emphasis ours

Whereas, The Workmen's Compensation Commission has authorized hospitals providing services to persons covered under the Workmen's Compensation Laws of this State to bill at their "posted charges," without having to request a hearing and without obtaining permission for any such increases in charges; and

Whereas, Under present regulations of the Workmen's Compensation Commission the individual physician is forced to request arbitration of fees by the Commission when Insurance Carriers elect not to pay the physician's Usual and Customary fees but abide rigidly to the Fee *Guide* published by the Workmen's Compensation Commission; and

Whereas, Within the Medical and Chirurgical Faculty's organization are reliable mechanisms through which questionable fees charged by physicians may be adjudicated; and

Whereas, At least ten other States already work under the concept of Usual, Customary and Reasonable fees for physicians' services in their handling of Workmen's Compensation cases; and

Whereas, There is no reason for medical services rendered to Workmen's Compensation recipients to be compensated for at fees differing from those received for such services rendered to other patients, now therefore, be it

Resolved, That Physicians in Maryland be urged to advise all insurance carriers that they intend to charge their Usual, Customary and Reasonable fees for Workmen's Compensation cases seen by them; and be it further

Resolved, That Insurance Carriers who continue to arbitrarily reduce fees paid to physicians for such Workmen's Compensation cases be taken to court so that a test case can be made to determine if they are in violation of the law as it is presently written; and be it further

Resolved, That physicians who elect not to see such Workmen's Compensation Cases because of this arbitrary attitude on the part of the groups involved so notify the Insurance Carriers, requesting them to seek the services of other physicians for care of such patients.

RESOLUTION 1A/69 ADOPTED AS AMENDED

Dr. Leighton, on behalf of the Reference Committee, moved adoption of Resolution 1A/69, as amended. The House adopted Resolution 1A/69, as amended, which read as follows:

Whereas, We as physicians have noted a tremendous increase in the number and type of the various group health insurance programs; and

Whereas, We believe these programs if properly handled can be of great benefit to both employers and employees as well as the general public, and

Whereas, There is a current tendency on the part of some insurance companies to reduce policy benefits in order to sell substandard policies at lower prices to employers who are not aware of the facts and who lack

the requisite expertise to compare and evaluate competing plans; and

Whereas, Physicians through their national, state and county medical societies are in a unique position to advise and counsel with employers, employees, insurance companies and the general public in health insurance matters; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland establish a committee whose purpose it shall be to formulate model group hospital and medical insurance master policies for use by employees, employers, insurance companies and members of the general public in this State; and be it further

Resolved, That said committee shall thereafter furnish consultation services to interested persons, firms or groups with respect to such insurance programs so that each party to such transactions can be made fully aware of the essential elements of proposed insurance plans in order that they may intelligently evaluate and compare the same.

RESOLUTION 2A/69 REJECTED

Dr. Leighton on behalf of the Reference Committee, moved that Resolution 2A/69 *NOT* be adopted. The House, after debate, rejected Resolution 2A/69, which read as follows:

Whereas, The Joint Commission on Accreditation of Hospitals specified that:

". . . the Joint Commission on Accreditation of Hospitals reaffirms its conviction that history-taking and physical examination of a patient admitted to a hospital is a part of the practice of medicine; their unsupervised performance and unreviewed recording by medical students are not conducive to the best quality of medical care, are not a useful learning experience, and may place the extern, the attending physician and the hospital in legal jeopardy. They cannot therefore be considered acceptable practices in an accredited hospital, as either an economic resource for students or a time-saving device for physicians."

and,

Whereas, It is obvious from such a statement that any patient who is scheduled for surgical procedures or who is in need of a medical regime that requires the skills of a licensed physician should have such history and physical examination authenticated by the attending physician or a qualified individual (by that is meant a licensed physician); and,

Whereas, It has become known that this is not always the practice that is being followed in some hospitals that utilize the services of externs; and

Whereas, Such practices cannot be condoned under any circumstances; be it, therefore,

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland, in the interest of better patient care, requires that BEFORE SURGICAL PROCEDURES ARE PERFORMED AND BEFORE MEDICAL REGIMES OR TREATMENT ARE ESTABLISHED, that histories and physicals performed by externs or house staff, be properly authenticated and approved by a legally licensed physician.

RESOLUTION 3A/69 REJECTED

Dr. Leighton, on behalf of the Reference committee, moved that Resolution 3A/69 *NOT* be adopted. The House rejected Resolution 3A/69, which read as follows:

Whereas, The American Medical Association has sent guidelines to the Medical and Chirurgical Faculty dealing with telephone listings of physicians; which included a statement that control should be at the local society level; and

Whereas, The Medical and Chirurgical Faculty Council (11-11-67) has taken action to enforce its own interpretations of these guidelines without placing control at the local society level; and

Whereas, The enforced terminology "practice limited to" without further explanation has been misinterpreted by patients, in some localities, that certain doctors no longer practice subspecialties; therefore, be it

Resolved, That telephone listings should be made in accordance with guidelines established by the local component societies which will consider, but not necessarily rigidly adhere to the guidelines established by the American Medical Association as interpreted by the Council of the Medical and Chirurgical Faculty; and be it further

Resolved, That a copy of this resolution be forwarded to the C & P Telephone Company and to the Reuben H. Donnelly Telephone Directory Company.

RECORDING OF VOTE

The Washington County delegation was granted permission to have it recorded in the minutes that the delegation had voted to support the resolution as introduced; and as it was instructed to do by its component society.

RESOLUTION ON APPOINTMENT OF SECRETARY OF HEALTH AND MENTAL HYGIENE

Timothy Baker, MD, requested consideration by the House of a motion dealing with the appointment of a Secretary of Health and Mental Hygiene by the Governor. By more than a two-third vote, the House voted to consider this motion. The motion, then adopted by the House by unanimous vote, read as follows:

That, the Medical and Chirurgical Faculty of Maryland goes on record as offering the Governor any advice, information, or consultation that he should wish in connection with the important task of appointing a Secretary of Health and Mental Hygiene.

BYLAW AMENDMENT PROPOSAL REJECTED

Raymond C. V. Robinson, MD, on behalf of the Baltimore City Delegation, offered the following motion to the House which, after debate and a division vote was rejected by 20 in the affirmative and 60 in the negative.

On behalf of the Baltimore City Medical Society delegation, I move that the Bylaws Committee be directed to prepare a bylaw amendment for presentation to the semiannual meeting in September 1969, whereby those component societies which are guaranteed representation on the Council by the bylaws, may elect those Councilors it wishes to have represent it.

NEW PRESIDENT

The Chair then introduced Russell S. Fisher, MD, new Faculty President, who assumed the chair.

ANNOUNCEMENTS

The Chair then made certain announcements.

ADJOURNMENT

The President, by general consent, declared the House adjourned *sine die*, at 3:25 P.M.

WILLIAM A. PILLSBURY, MD, *Secretary*

BALTIMORE OXYGEN SUPPLY CO., INC.

OHIO CHEMICAL DISTRIBUTORS

Therapy and Medical Gases
and Oxygen Tents
Resuscitators and Apparatus

Main Office & Plant: Linthicum, Md. 789-8100
Warehouse: 1611 Guilford Ave., Baltimore, Md. 727-4748
Branch: 2426 Linden Lane, Silver Spring, Md. 582-2094

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

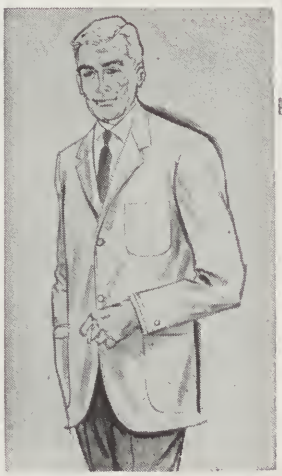
#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#800—100% Nylon Taffeta **$5.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only

Sizes 34 to 46





MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab. **$9.99**

Sizes 28-40

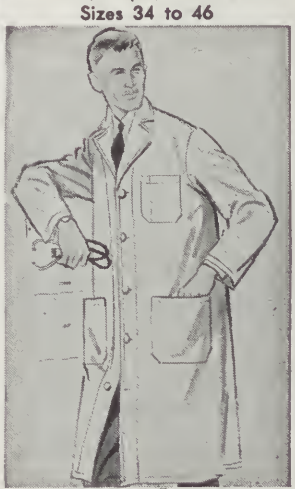
- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46



OTHER STORES IN →

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639

PROJECT MANAGEMENT
CONSULTANTS
TO
FRANKLIN SQUARE HOSPITAL

CONSTRUCTION
COST CONTROL

CONSTRUCTION
MANAGEMENT

McKEE - BERGER - MANSUETO INC.
CONSTRUCTION CONSULTANTS
ENGINEERS



THE JEWETT
REFRIGERATOR
COMPANY, INC.

manufacturers of

Blood Bank equipment,
Mortuary-Autopsy equipment
and
Clinical Refrigerators of
every type

CONGRATULATES
FRANKLIN SQUARE HOSPITAL

on its fine new facility

THE JEWETT REFRIGERATOR CO., INC.
2 Letchworth Street, Buffalo, New York 14213



QUALITY
with
THRIFT

CALL Campbell FOR

- READY MIXED CONCRETE
- SAND AND GRAVEL
- CRUSHED STONE
- Special WHITE AGGREGATES
- PAVING

And at your dealers . . .

SAKRETE
PRODUCTS

HARRY T. CAMPBELL SONS CORPORATION
Campbell Bldg. Towson, Md. . . . VA 3-7000
A Subsidiary of THE FLINTKOTE COMPANY

AMERICA'S
No. 1
CAR

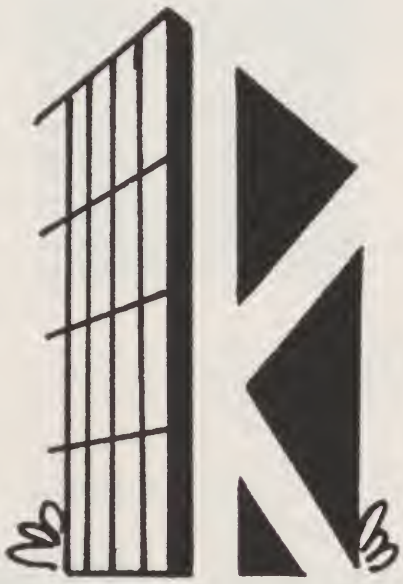
Charlie Irish

CHEVROLET, INC.
7900 EASTERN AVE., BALTIMORE 24, MD.
Opposite Eastpoint
Telephone: 288-2500

Builders of

FRANKLIN SQUARE HOSPITAL

Dependable builders -- serving the Baltimore area since 1908



HENRY A. KNOTT, INC.

2406 GREENMOUNT AVENUE
BALTIMORE 18, MD. • HOPKINS 7-4970

Greenfeld Supply Co., Inc.

5503 REISTERSTOWN RD.
BALTIMORE, MARYLAND 21215
Phone No. 358-7200

DISTRIBUTORS OF
ACCESSORY SPECIALTIES
INC.

A complete line of toilet room accessories and specialty items. Including all types of soap, towel dispensers and disposal units, all types of grab bars, and many types of special dispensers.

FRANKLIN SQUARE HOSPITAL
selected

**CHASE
WATERPROOFING CO., Inc.**

Waterproofing *Dampproofing*
Caulking

2100 West Lanvale St.
BALTIMORE, MARYLAND, 21217

Associated in the building of
FRANKLIN SQUARE HOSPITAL

**WALBROOK MILL &
LUMBER CO.**

A Complete Lumber Yard Since 1918

ARCHITECTURAL & SPECIAL MILL WORK

2636 W. North Ave. Phone 566-2200
BALTIMORE, MD. 21216

OUR THANKS

To the professional and hospital personnel
who have contributed their knowledge—
concern—and effort to complete

FRANKLIN SQUARE HOSPITAL

"providing the people of greater
Baltimore with Better Patient Care"

Puritan-Bennett Corporation
Race and McComas Streets
Baltimore, Maryland

Central Supply Piping Systems – Medical Gases
Inhalation Therapy and Suction Equipment

Associates in the building of
FRANKLIN SQUARE HOSPITAL

ELECTRICAL CONTRACTORS
E. C. ERNST, INC.

2000 L ST. N. W. WASHINGTON, D. C.

Branch Offices

NORFOLK, VA.	HARRISBURG, PA.
RICHMOND, VA.	PITTSBURGH, PA.
NEWPORT NEWS, VA.	PHILADELPHIA, PA.
ATLANTA, GA.	NASHVILLE, TENN.
AUGUSTA, GA.	GULFPORT, MISS.
DECATUR, ALA.	ORLANDO, FLA.

BALTIMORE, MD.

Franklin Square Hospital Nearing Completion

The new $7,000,000 Franklin Square Hospital on Ridge Road, in eastern Baltimore County, is taking its final shape and will be ready for occupation late this year.

Widely heralded as an advanced concept in hospital design, the modern facility will house its patients in a four-story wing which extends 330 feet along one elevation. Adjoining is the two-story core of the hospital where diagnostic and treatment activities will be centered. The building is reinforced concrete with a brick facing. Tinted glass will be used to reduce the glare in the aluminum window frames. Floor space is the equivalent of about four acres.

Facilities in the hospital will include seven operating rooms, an X-ray department, and pathology laboratory, as well as thoroughly up-to-date emergency equipment.

Patient rooms will be equipped with toilets. Lavatories will be adjacent to each bed. Each room has been designed with a comfortable alcove in which the patient can relax and enjoy the attractive landscaping around the hospital.

In addition to the usual closets for clothing and personal effects, the rooms will have "pass through" cupboards in which patient supplies are placed from the corridor and removed through doors inside the room.

The modern lighting system will combine general illumination with reading light. Two-way patient-nurse communication is being installed; and switches, television controls, and nurse calls will be placed to insure the utmost in patient convenience.

The new Franklin Square Hospital will be the first in this area to use the "convenience" food system. Food will be supplied by major processors in the form of frozen, prepared meals. This system will permit the hospital to offer a more uniform quality and greater variety of food at a lower cost.



The hospital is an important unit in the health-education complex that includes Essex Community College and a county health center. Franklin Square is now engaged in raising funds to purchase all new equipment and furnishings for the building; and to expand its medical staff to meet the heavier patient load at the new site.

The Franklin Square Foundation, created for "charitable, scientific, and educational purposes", is considering the construction of other buildings to increase the complex and provide space for offices, laboratories, related facilities, and housing for interns and residents.

NEW SURGERY HEAD



Dr. Ferris

Philip J. Ferris, MD, of Washington, D.C., has been named full-time director of the Department of Surgery at Franklin Square Hospital, effective July 1, 1969.

As director, Dr. Ferris will be responsible for the organization of all surgical activities, including sub-specialty appointments, and will direct an American Medical Association - approved four-year program for training new surgeons.

Dr. Ferris was a scholarship student at The Johns Hopkins University, from which he received an AB in 1954. In 1958, he received his MD from The Johns Hopkins University School of Medicine.

* * *

George A. Lentz, Jr., MD, assistant professor of pediatrics, and preventive medicine and rehabilitation, has been appointed assistant dean for student affairs in the University of Maryland School of Medicine.

* * *

Robert Traub, PhD, research professor in the department of microbiology, University of Maryland School of Medicine, returned to Baltimore in December from a three-and-a-half month visit to New Guinea, where he was conducting research on viral and rickettsial infections. On his return, Dr. Traub was invited by the Entomological Society of America to present two papers at its meeting in Dallas, December 2-6.

* * *

On January 9-10, **Erland Nelson, MD,** professor and head of the department of neurology, **Jerome Merlis, MD,** professor of neurology and clinical neurophysiology, **Albert Heck, MD,** associate professor of neurology, and **Thomas Price, MD,** assistant professor of neurology, represented the University of Maryland School of Medicine at the Third Annual Cerebrovascular Clinical Research Center Workshop in San Juan, Puerto Rico.

* * *

Richard D. Richards, MD, professor and head of the department of ophthalmology, and **Drs. Moritz Michaelis** and **Stanley S. Schochet,** both associate professors of ophthalmology, University of Maryland School of Medicine, presented a paper at the annual meeting of the Association for Research in Ophthalmology in Sarasota, Florida, on April 20-24. The Atlantic Section meeting of the association, which was held in Baltimore on March 7-8, was organized by the department of ophthalmology.

* * *

Harlan I. Firminger, MD, professor of pathology, University of Maryland School of Medicine, chaired a session on neoplasia at the American Association of Pathologists and Bacteriologists in San Francisco in March. At the same meeting, **Si Chun Ming, MD,** associate professor, and **Pen Ming Ming, MD,** assistant professor, both in the department of pathology, delivered a paper.

* * *

Roy Hertz, MD, has been awarded the Ann Langer Cancer Research Foundation Award for 1969 for his effective chemotherapy of trophoblastic tumors in women. Dr. Hertz is chief, Reproduction Research Branch, National Institute of Child Health and Human Development, National Institutes of Health, Bethesda, Md.

The Ann Langer Cancer Research Foundation is a Chicago group with a membership of 150 lay persons who raise funds for cancer research. To date, over $200,000 has been given by this foundation to such groups as, the University of Chicago Cancer Research Foundation, Mount Sinai Hospital, Hebrew University in Jerusalem, and others.

* * *

AMA President-elect, **Gerald D. Dorman, MD,** of New York city, has been named to the HEW Advisory Committee on Health Protection and Disease Prevention. The committee is being asked to make recommendations on the role of the federal government in preventing illness, and in planning a major expansion of the effort to reduce the incidence of disease. A report is due by February 1, 1970.

* * *

A Drug Abuse Clinic that initially can treat 40 to 50 narcotic addicts on an outpatient basis has been formed at The Johns Hopkins Medical Institutions, and is accepting its first patients. **Leon Wurmser, MD,** is the clinic director.

The clinic's programs are being financed by grants from the Federal Department of Health, Education and Welfare, and the State Department of Mental Hygiene. The state already has made the first of six annual $40,300 payments.

* * *

The National Institute of Mental Health has launched an intensive drug abuse information program. A Washington metropolitan area television and radio campaign is the first phase of an all-media national effort.

Nation-wide advertising began in April, dealing with the dangers of LSD, amphetamines, barbiturates, narcotics, and general drug abuse. The commercials also stress the legal penalties for possession and use of marihuana.

Stanley F. Yolles, MD, Director of the Institute, has stated that the advertising will be supplemented by a national grassroots educational program. Films and question-and-answer fliers are already in circulation.

* * *

The Association of American Physicians and Surgeons, Inc., in its April Newsletter that reaches physicians in all 50 states, singled out the members of **The Professional Forum of Baltimore** "for their important assistance to AAPS and to its Committee for the Education of Medical Students, Interns, and Residents."

Selected for this accolade was **Jack Rytten,** a Baltimore criminologist and investigator, who is president of The Professional Forum, and **Henry L. Wollenweber, MD,** who serves as vice-chairman of the Forum's Committee On Medicine. Dr. Wollenweber also serves as liaison coordinator between The Professional Forum and the Association of American Physicians and Surgeons, Inc., a Chicago-based, nation-wide group of physicians.

In a statement to *The Daily Record,* Mr. Rytten said: "The Professional Forum will continue to give its unwavering support to the immediate and long-range goals of the Association of American Physicians and Surgeons, Inc. in that group's efforts to restore the Free-Enterprise Concept to the practice of medicine."

* * *

Robert E. Cooke, MD, pediatrician-in-chief at The Johns Hopkins Hospital, and **Ralph W. Gause, MD,** chairman of the department of obstetrics and gynecology, the Roosevelt Hospital, New York city, have been appointed medical consultants to the National Foundation-March of Dimes. Dr. Cooke will work closely with the Foundation's efforts to improve the care and treatment of children with birth defects, and Dr. Gause will assist in development of expanded programs in prenatal care to prevent birth defects.

* * *

Dr. Cooke was the principal speaker at the April 21 dedication ceremonies for the Center for Developmental and Learning Disorders at the Medical Center of the University of Alabama.

* * *

Octavio deMarchena, MD, has been Board Certified by the American Board of Surgery.

* * *

D. S. Hathaway, MD, who has been a resident in nephrology in the Mayo Graduate School of Medicine, University of Minnesota at Rochester, has left that city and will be located in Bethesda, Maryland.

* * *

Jon Valigorsky, MD, intern in pathology, University of Maryland Hospital, presented a paper at the April meeting of the Federation of Societies for Experimental Biology and Medicine in Atlantic City.

* * *

Governor Marvin Mandel and the members of the Maryland General Assembly have been praised for their action on Maryland's community mental health program by **Reuben Shiling,** President of the Maryland Association for Mental Health (MAMH).

Mr. Shiling lauded Governor Mandel's inclusion of $1.8 million for community mental health services in his Supplementary Budget Request. The General Assembly approved the request in full.



Governor Mandel

* * *

William G. Esmond, MD, assistant professor of surgery, University of Maryland School of Medicine, presented an exhibit and six papers at the 21st Annual Conference on Engineering in Medicine and Biology in Houston, Texas, in November. He has also prepared a scientific display for the April meeting of the American Association for Artificial Internal Organs in Atlantic City.

* * *

The Maryland Association For Mental Health (MAMH) has published a brochure entitled, "Your Mental Health Association in Maryland." The brochure, which is free to the public, outlines the purpose of mental health associations and illustrates some of their activities. Copies may be obtained by contacting the MAMH at 2104 North Charles Street, Baltimore, Maryland 21218.

* * *

The world's most powerful neutron generator designed specifically for cancer research, **the Dynagen IV,** developed and manufactured by Radiation Dynamics, Inc., will be used by the Cleveland Clinic in a research program for tumor therapy.

According to **Antonio Rodriquez-Antunez, MD,** director of the Cleveland Clinic's Radiation Therapy and Nuclear Medicine Department, recent cancer investigations have shown some distinct advantages of fast neutron treatment as compared to conventional super-voltage X-ray and cobalt 60 teletherapy techniques. These investigations have been underway for a number of years at the Hammersmith Hospital, London, England, and have demonstrated limited success for the treatment of large, solid tumors.

* * *

Directors of state comprehensive health planning agencies have organized into the **American Academy of Comprehensive Health Planning** (AACHP). The Academy, whose bylaws were officially approved on March 5, has been formed to promote increased understanding of comprehensive health planning. The new organization will also serve as an information exchange among national, state, and local comprehensive health planning authorities and agencies.

Eugene H. Guthrie, MD, executive director of the Maryland Comprehensive Health Planning Agency, was elected Chairman of the AACHP.

* * *

On May 1st, the **Institute of International Education** officially opened its competition for 275 grants for graduate study or research abroad, and for professional training in the creative

and performing arts during the academic year 1970-1971.

IIE annually conducts the competition for U.S. Government Awards under the Fulbright-Hays Act and the competition for grants offered by various foreign governments, universities, and private donors. The purpose of the grants is to increase mutual understanding between the people of the U. S. and other countries through the exchange of persons, knowledge, and skills.

Candidates who wish to apply for an award other than in medicine must be U. S. citizens at the time of application, have a bachelor's degree or its equivalent before the beginning date of the grant, and, in most cases, be proficient in the language of the host country. Applicants in the field of medicine must have an MD degree at the time of application.

Selections will be made on the basis of academic or professional record or both, the feasibility of the applicant's proposed study plan, language preparation, and personal qualifications. Preference is given to applicants between the ages of 20 and 35 and to candidates who have not had prior opportunity for extended study or residence abroad, with the exception of those who have served in the armed forces.

* * *

In response to a growing program funded by the National Institute of Mental Health, a reorganization and a new post within the NIMH Division of Mental Health Service Programs has been announced by **Alan I. Levenson, MD,** Division Director.

The program—federal aid for the construction and staffing of community mental health centers—will be handled by a new Community Mental Health Centers Support Branch. Previously, two separate branches of the division administered grants to centers.

Appointed to the newly-created Post of Associate Director for Community Mental Health Services is **Saul Feldman, MD.**

* * *

David B. Skinner, MD, assistant professor of surgery, The Johns Hopkins University School of Medicine, has been appointed a Markle Scholar in Academic Medicine by the John and Mary R. Markle Foundation of New York.

The 34-year-old surgeon is one of 25 young medical scientists, all faculty members of medical schools in the U. S. and Canada, selected by the Foundation to receive the $30,000 awards. The money will be paid at the rate of $6,000 per year for five years to the medical schools where the scholars teach and conduct research.

* * *

The outpatient clinic of **Springfield State Hospital** moved from its present location at 2100 Guilford Avenue to its new site at 2646 North Charles Street on April 7.

According to **Frederick Pokrass, MD,** acting hospital superintendent, the new facilities have been made available through the philanthropic generosity of the United Order of True Sisters, Inc. Baltimore #35 which is defraying rental costs.

Evelyn J. Nelson, MD, is clinic director and **Mrs. Robert Taylor** is True Sisters president.

* * *

The newly-created **department of neurology** at The Johns Hopkins University School of Medicine will add five new faculty members to its staff July 1, according to **Guy M. McKhann, MD,** Kennedy Professor and director of the department. The new faculty members are:

Richard C. Johnson, MD, who has been appointed Dwight D. Eisenhower-United Cerebral Palsy Clinical Professor of Neurology. Dr. Johnson is now associate professor of neurology at Case Western Reserve School of Medicine and a neurologist at the Cleveland Metropolitan Hospital.

Daniel B. Drachman, MD, who has been appointed associate professor of neurology, is an assistant professor of neurology at Tufts University.

John M. Freeman, MD, who has been appointed associate professor of neurology, is an assistant professor of pediatrics and medicine (neurology) at Stanford University.

Robert M. Herndon, MD, who has been named associate professor of neurology, is an assistant professor of Medicine (neurology) at Stanford University.

Leslie P. Weiner, MD, who has been appointed assistant professor of neurology, is a special research fellow at The Johns Hopkins School of Hygiene and Public Health.

* * *

Erland Nelson, MD, has just received support in the form of a $10,000 grant from the National Institute of Neurological Diseases and Stroke to test whether reducing moderate hypertension in patients who have suffered one stroke will help them to avoid another one.

Dr. Nelson is head of the department of neurology at the University of Maryland School of Medicine. Collaborating with him in his work are: **Albert F. Heck, MD,** project director; **Thomas R. Price, MD,** and **John W. Eckholdt, MD,** neurologists; **Y. C. Lee, MD,** cardiologist; **William Law, MD,** internist; and nurse **Carol Haina,** project coordinator.

* * *

Vernon E. Krahl, MD, professor of anatomy at the University of Maryland School of Medicine, has found a way to treat a disease, sometimes referred to as

respiratory distress syndrome of the newborn, that tops the list for fatalities among newborn babies. Dr. Krahl prefers to call the disease pulmonary hypoperfusion syndrome (PHS) because his observations have convinced him that the basic trouble is inadequate blood flow in the capillary bed of the lungs.

Dr. Krahl has accepted an invitation to spend several months at the Katholiek Universiteit te Leuven in Louvain, Belgium, in collaborative study of PHS with Professor Joseph Lauweryns, head of the school's department of histopathology, and Nadia Bourgeois, MD, pediatrician.

* * *

Howard A. Naquin, MD, has been re-elected as president of the board of directors of the Maryland Society for the Prevention of Blindness. He will serve a one-year term to expire in 1970.

Also re-elected to the board of directors were **Richard E. Hoover, MD, Arnall Paz, MD,** and **Richard D. Richards, MD. Angus L. MacLean, MD,** is among the members of the board.

* * *

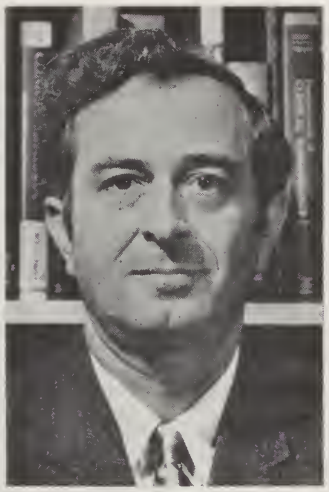
Julio E. Alarcon, MD, a resident at University of Maryland Hospital in Baltimore, has placed third in the 1969 SAMA-Eaton Medical Art Award Competition. Dr. Alarcon received $50 and a plaque for his medical illustrations.

* * *

Louis C. Lasagna, MD, director of the Division of Clinical Pharmacology at The Johns Hopkins University School of Medicine, is featured in the cover story of the April 7, 1969 issue of *Modern Medicine.*

Dr. Lasagna, selected by the medical journal's editors as their "Contemporary" for this issue, gives his opinions about care of retarded children (his son is a mongoloid child), doctor use, and patient attitudes toward drugs, including oral contraceptives, and the trend toward active participation by students in shaping educational programs.

For 16 years Dr. Lasagna has served at Johns Hopkins—the past 12 as division director and associate professor of pharmacology and experimental therapeutics. He served earlier, from 1951-1952, as an instructor and, from 1954-1956, as assistant professor of medicine and pharmacology. He also managed to find time to author the book, *Life, Death and the Doctor.*



Dr. Lasagna

* * *

The Suburban Maryland Chapter of the Washington Psychiatric Society has elected the following officers: **Henry P. Laughlin, MD,** chairman; **Brian Crowley, MD,** vice chairman; and **Kenneth Gaarder, MD,** secretary-treasurer.

Membership in the new organization is open to psychiatrists who practice or reside in Montgomery or Prince Georges counties.

* * *

The Air Pollution Control Association is soliciting papers for the **December 1970 Conference of the International Union of Air Pollution Prevention Associations** to be held in Washington, D.C.

Subjects include Medicine and Biology—the effects of air pollution on people, animals, and vegetation; and Air Pollution Surveys—papers reporting community and area studies. **Proposals to present papers may be submitted from July 1969 to January 31, 1970, the deadline.** Papers from the United States of America should be sent to Professor Arthur C. Stern, Program Co-Chairman, Department of Environmental Sciences and Engineering, School of Public Health, University of North Carolina, P. O. Box 630, Chapel Hill, N.C. 27514.

* * *

The formation of a **Mental Health Advisory Committee to the Baltimore City Health Department** has been announced. This group, consisting of leaders in the field of mental health and others whose daily work brings them in close association with the problems of mental health, will serve to coordinate and plan for the improvement and expansion of mental health programs in the Baltimore area.

Members of the committee include: Irvin H. Cohen, MD, director of training at Sheppard & Enoch Pratt Hospital; John H. Hirschfeld, president of the Baltimore Area Council on Alcoholism; Michael J. Bisco, MD, a member of the Maryland Association of Private Practicing Psychiatrists; Addison W. Pope, MD, regional mental health director of the Department of Mental Hygiene; and Paul V. Lemkau, MD, professor, Department of Mental Hygiene, The Johns Hopkins School of Hygiene and Public Health.

* * *

Rx SCOTSMAN® ICE MACHINES

DOSAGE: ONE AT EVERY NURSES STATION

This Scotsman prescription will save your hospital time, money and steps as it will for Franklin Square Hospital in Baltimore. The New Franklin Square is assured of a continuous ice supply where and when they need it at a cost of as little as 8c per 100 pounds. 100% pure Scotsman ice meets the highest sanitary standards. This free-flowing flaked ice can be used for food service, oxygen tents, surgery, ice packs and kitchens. For complete information, mail coupon below today.



Counter top icemaker-dispenser offers speed, portion control, eliminates handling. Produces up to 200 pounds of Super Flakes per day. Model ACD-1 produces up to 525 pounds. AD-2 model produces 650 pounds.

NELCO CORPORATION

3012 Greenmount Avenue

Baltimore, Maryland 21218

Phone: 301/467-4200

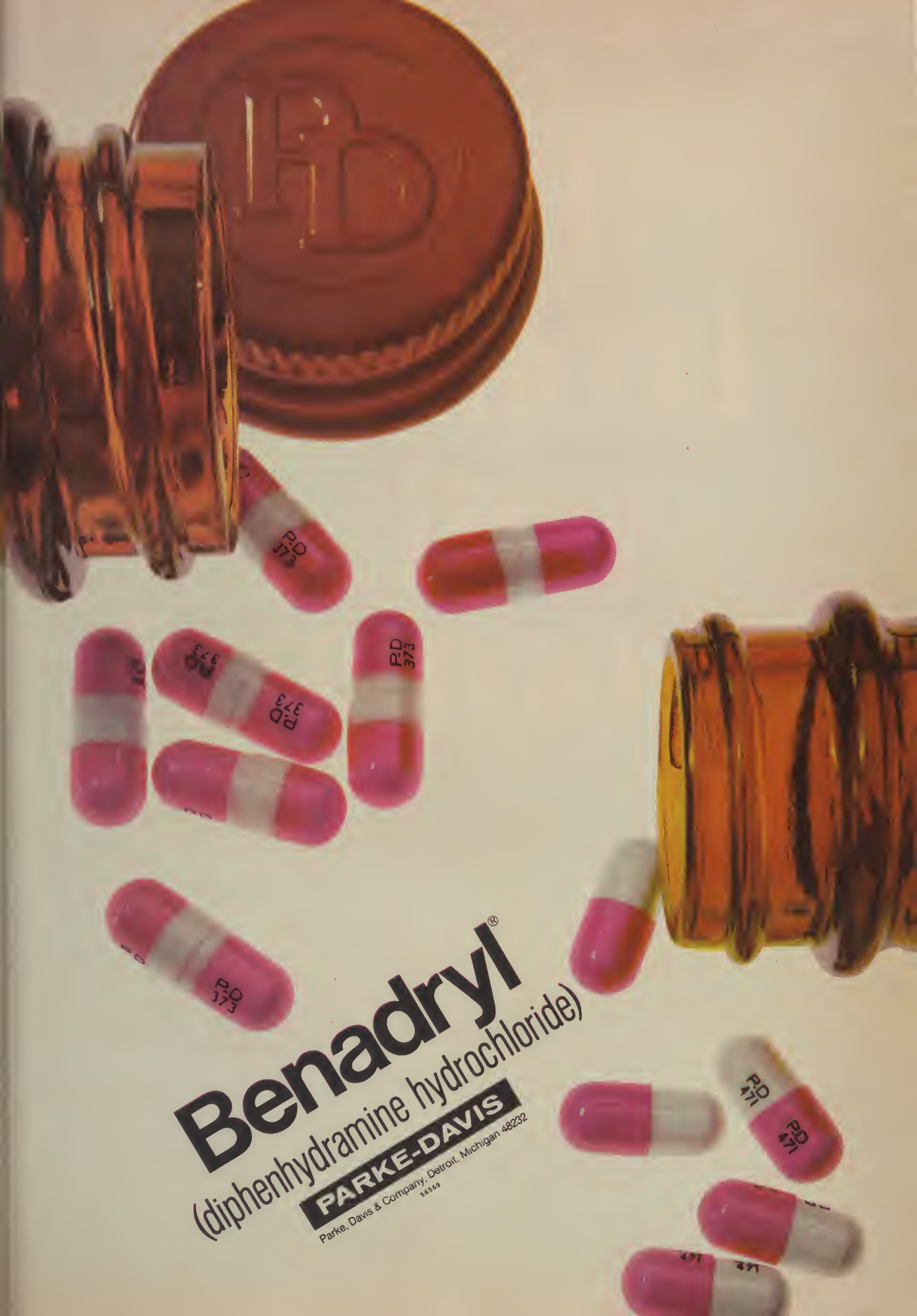
Gentlemen:
Send more information on your convenient ice and water service.

Name .....

Hospital .....

Address .....

City ..... **State** ..... **Zip** .....


Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
55559

The trouble with women...



frequently is men

FLAGYL®
brand of metronidazole

Cures Trichomonal Infection in Both

Although *Trichomonas vaginalis* infection occurs in only 5 to 10 per cent* of men, careful diagnosis will demonstrate the condition in about half of all husbands of infected women. Nine investigators* reported an average incidence of 50.8 per cent in exposed consorts.

Many clinicians have achieved a high degree of success in treating trichomonal vaginitis only after they have recognized the importance of sexual partners in perpetuating the infection. Crowley* has asserted, "it was not until we acted on this key premise that we were able to obtain positive and lasting results in our management of recurrent vaginal trichomoniasis."

Simple ten-day oral treatment with Flagyl virtually assures elimination of established trichomonal infection in men. In twenty-two of twenty-seven studies* data on the results of treating male patients revealed that all men treated with Flagyl were cured.

Indications: Flagyl is indicated in the treatment of trichomoniasis in both men and women.

Contraindications: Pregnancy; disease of the central nervous system; evidence or history of blood dyscrasia.

Precaution: Complete blood cell counts should be made before, during and after therapy, especially if a second course is necessary.

Side Effects: Infrequent and minor side effects include nausea, metallic taste and furry tongue. Gastrointestinal disturbances, flushing and headache sometimes occur, especially with concomitant ingestion of alcohol. The taste of alcoholic beverages may be altered. Other effects, all reported in an incidence of less than 1 per cent, are diarrhea, dizziness, vaginal dryness and burning, dry mouth, rash, urticaria, gastritis, drowsiness, insomnia, pruritus, sore tongue, darkened urine, anorexia, vomiting, epigastric distress, dysuria, depression, vertigo, incoordination, ataxia, abdominal cramping, constipation, stomatitis, numbness or paresthesia of an extremity, joint pains, confusion, irritability, weakness, cystitis, pelvic pressure, dyspareunia, fever, polyuria, incontinence, decreased libido, nasal congestion, proctitis and pyuria. Elimination of trichomonads may aggravate candidiasis.

Dosage and Administration: *In women:* one 250-mg. oral tablet three times daily for ten days. A vaginal insert of 500 mg. is available for local therapy when desired. When used, one vaginal insert should be placed high in the vaginal vault each day for ten days; concurrently two oral tablets should be taken daily.

In men: When trichomonads are demonstrated, one 250-mg. oral tablet twice daily for ten days in conjunction with treatment of his female partner.

Dosage Forms: Oral tablets—250 mg.
Vaginal inserts—500 mg.

*Complete list of references on request.

SEARLE

Research in the Service of Medicine



...now fast relief of hay fever symptoms with

NTZ®

Nasal Spray



When pollens fly, just one or two squirts of NTZ in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The antihistamine component of NTZ helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

NTZ Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:

Neo-Synephrine® (brand of phenylephrine) HCl, 0.5% (adult strength), decongestant
Thenfadil® (brand of thenyldiamine) HCl, 0.1%, antihistamine
Zephiran® (brand of benzalkonium as chloride, refined) Cl, 1:5000, antiseptic wetting agent

Treatments with NTZ should be repeated every three or four hours as needed. NTZ is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

Winthrop Laboratories, New York, N.Y. 10016 (1289)

Winthrop

IN BALTIMORE.....

House In The Pines Nursing Homes have the facilities and experience to care for those you care for



HOUSE IN THE PINES
NURSING HOMES

PROFESSIONAL CARE FOR THE AGED, CHRONICALLY ILL AND CONVALESCENT.

• Bright, pleasant surroundings and a home-like atmosphere • Fire-safe accommodations • Competent professional care, 24 hours a day • Complete Physical and Occupational Therapy facilities and programs under the direction of our licensed staff therapists

• Modern kitchens supervised by licensed staff dietitian provide tasty, balanced meals.

BEL AIRE — 5837 Belair Road — CL 4-8800
BELVEDERE — 2525 W. Belvedere Ave. — FO 7-9100
CATONSVILLE — 16 Fusting Ave. — RI 7-1800
also Easton, Md., Rt. 50 & Dutchman's Lane. TA 2-4000

YOUR INSPECTION INVITED • BROCHURE ON REQUEST

Your Pathologist

is a Practicing Physician Like Yourself —

Be Loyal To His Local Laboratory

Dear Doctor:

Our laboratory was established to provide the practicing physician with a private laboratory that maintains standards and quality control presently available only in leading medical centers. The laboratory is physician owned and operated.

Prominent consultants in academic medicine from the fields of clinical chemistry, microbiology, hematology, and cytology work actively along with our Directors, all of whom hold Doctorate degrees, to assure that all diagnostic services performed continue to meet the physicians' demands for quality laboratory results. Our laboratory is unique because our consultants are available to the referring physicians for interpretation and advice concerning unusual and interesting cases, as well as routine cases.

Our highly skilled technicians, modern equipment, and computerized procedures permit us to offer the most rapid service available. We provide the required supplies and containers (postage paid, if necessary) for all of our diagnostic services. In addition, specimen collection service is available in many areas.

We are dedicated to maintaining prices that are competitive, and we feel we offer more to the physician and his patients than any existing laboratory. Either patient or physician billing is available.

Please return the enclosed postcard for further information. Thank you for your time.

Yours truly,



When you read the above letter, and others similar to it which you receive from time to time, you just have to get *mad* . . . not angry . . . *mad!*

Pathology is the basis of good medicine, just as it was when all of us were medical students. Private physicians practicing pathology are the best professional friends doctors in private practice have. Their laboratories are the keystone of good medical practice. We have excellent pathologists and excellent physician-pathologist laboratories in Baltimore and the State of Maryland. This is why I get *mad*—and you should too!—when out-of-state laboratories malign the value of my local pathologist and his laboratory, downgrade the fellow physician-practitioner who helps me most to practice good medicine, and callously advertise for my referrals.

The laboratory that I use in Baltimore is physician owned and operated. It maintains standards and quality control above that presently available to me in leading medical centers, because it is tailored to my private patients needs, and is personalized in its relationship to my practice. My pathologist does not need Directors who hold Doctorate degrees to assure quality results because my pathologist *is* the director, and his MD degree and board certification in Pathology qualifies him to guarantee me quality results. If he needs conference regarding an unusual case, he has access to consultants in the University of Maryland and The Johns Hopkins hospitals where he is privileged to practice. He has highly skilled technicians. He does not need postage-paid containers for my patients because they report to his office, but he provides this service for out-of-area patients, provided he has a clinical history to go along with his tests. He has no interest in competitive "prices" and he does not send me a bill; he collects from the patient a fee for his services, just as does any other physician or surgeon consultant when I refer a patient.

Above and beyond everything else, my pathologist and his laboratory offers to me and my patients more than any other laboratory, and I bitterly resent the idea that this laboratory is paranoid enough to feel that it offers more than "any existing laboratory."

Every physician should realize that

(1) Pathology-laboratory medicine is the practice of medicine.

(2) Pathologists who own and operate private laboratories are consultants in the practice of pathology and laboratory medicine.

(3) Fees for service are due to these consultants as to any other specialist-consultant.

(4) The referring physician should *NOT* be billed for pathology-laboratory fees; other specialist-consultants (surgeon, cardiologist, etc.) do not bill the referring physician.

(5) The Pathologist in private practice is a practicing physician . . . be loyal to him, and to his *local* laboratory.

JOHN F. SCHAEFER, MD
Baltimore

Occipital Neurectomy in the Treatment of Headache

Results in 30 Cases

The primary treatment of any headache problem is, and properly should be, medical management. If a therapeutic response is not prompt and satisfactory, the next step is to investigate further whether or not an intracranial source of the chief complaint exists. When electrographical and neuroradiological studies prove to be normal and headaches persist, in spite of what should be a predictably efficacious program of medication, the patient is often, if not usually, told that his problem is psychosomatic—"tension . . . unrelieved hostility", or the like.

Psychic conflict and repressed aggression are so well recognized to be a competent producing source of pain in the cranial or cervical regions that expressions such as "a real headache" or "a pain in the neck" are used in all languages to describe or refer to situations or associations which inspire frustration, antagonism or rage. It is my belief, however, that the concept of "tension headache" has been so widely and thoroughly oversold that many patients are denied, thereby, the opportunity to obtain effective relief from headache-producing cranial or cervical neuralgias by surgical means.

Those sufferers from occipitofrontal headaches who are unresponsive to medicinal therapy, and whose complaints are not due to serious intracranial conditions, have a disorder known generally as "occipital neuralgia". While there is no doubt that in many of these patients the condition is psychosomatic, pain in a significant and salvageable number of this group is of traumatic, of cervical arthritic, or other organic cause and simple surgery will afford relief which is usually prompt, satisfactory, and of long duration.

J. PETER MURPHY, MD
Chief, Subsection of Neurosurgery
Suburban Hospital
Bethesda, Maryland
Associate Clinical Professor of Neurosurgery
George Washington University Medical School
Washington, D.C.

Thirty patients were operated upon in this series. Occipital neurectomy was performed on one side only in 18; bilateral neurectomies were carried out in 12. Seven patients were 60 years of age or older, four were in their fifties, eight in the forties, ten in the thirties, and one was 26-years-old.

The effect of surgery was considered to be excellent in 18 patients, good in 7, fair in 3 and poor in 2. Follow-up was for 15 years in 1 patient, 12 years in another, 5 years in 2 patients, 3 years in 1, 2 years in 7 patients, 1 year in four, and for less than 1 year in 14 patients (Table 1).

TABLE 1

Number of patients	**30**	
Male	**16**	
Female	**14**	
Age:		
60's	**7**	
50's	**4**	
40's	**8**	
30's	**10**	
20's	**1**	
Etiology:		
Trauma		**9**
Cervical arthritis		**9**
Trauma and cervical arthritis		**1**
High blood pressure, alcoholism, cervical arthritis, neurosis		**1**
Neurosis		**3**
Arterial (vertebral) occlusion		**2**
Migraine		**1**
Sinusitis		**1**
Carcinoma of the lung with metastasis		**1**
Spasmodic torticollis		**1**
Postmastoidectomy neuralgia		**1**
Results from surgery:		
Excellent	**18**	
Good	**7**	
Fair	**3**	
Poor	**2**	
Followup:		
15 years	**1**	
12 years	**1**	
5 years	**2**	
3 years	**1**	
2 years	**7**	
1 year	**4**	
Less than one year	**14**	

Table 1.—Statistics of series of 30 patients in whom occipital neurectomy was performed.

The presumed causes of occipital neuralgia in the series were varied, but in the majority of cases the cause was thought to be trauma, cervical arthritis, or both conditions. Three patients were recognized to be obviously neurotic, but failure of other treatment, resistance to psychotherapy, desire for relief, and suggestively positive results from preliminary xylocaine nerve block, prompted surgery. As might be anticipated, the result in one patient was adjudged to be only fair, in the other two, it was definitely poor.

Excellent relief was obtained, rather surprisingly, in two patients—the onset of whose neuralgia dated definitely to the time of thrombosis of a vertebral artery, which was verified by arteriography in one case, and was assumed to be true on valid neurological grounds in the other. Migraine of atypical location was causative of neuralgia in one patient; results were "fair" at best after surgery. Sinusitis gave origin to symptoms in a young man; after all neurological and neuroradiological examinations, relevant to the presence of brain abscess, were normal, xylocaine nerve block pointed the way to completely effective surgical relief by occipital neurectomy. The severe neck pain resulting from spasmodic torticollis was eliminated by removal of the ipsilateral occipital nerve in a 66-year-old man, although the primary spastic condition was, of course, not affected thereby. Post-mastoidectomy neuralgia necessitated surgical treatment for one patient.

A complicating problem of previous alcoholism—to the extent of two bouts of pancreatitis, chronically recurring hypertension, severe neurosis, and temporarily immobilizing cervical arthritis—in one patient would not bespeak a predictably satisfactory result from any type of surgery. Complete, although temporary, cessation of occipitocervical headaches following nerve blocks justified performing a bilateral neurectomy, with ensuing and enduring symptomatic cure!

A last patient merits description as an instructive curiosity: carcinoma of the lung had been resected six years before. When right occipital headaches became associated with nystagmus and ataxia, the clinical impression was that of metastatic carcinoma of the right cerebellar hemisphere, particularly since an abnormal x-ray of the chest revealed a widened mediastinum. While debate progressed as to the preferable form of definitive therapy, increase in headache demanded symptomatic relief. Xylocaine nerve block caused immediate cessation of pain, but it recurred as the effect wore off.

Several interesting events ensued (1) right occipital neurectomy relieved the original occipitocervical pain completely; (2) histological examination of the nerve bundle removed disclosed infiltration of metastatic neoplastic carcinoma; and (3) herpes zoster developed in the domain of the greater occipital nerve and in the right side of the forehead. It has long been known that occipital neuralgia and conditions causing it produce pain in the ipsilateral forehead and eye, as well as in the occipitocervical area. And it has been demonstrated experimentally in human volunteers that injection of an irritating solution into the second cervical nerve root evokes immediate pain in the ipsilateral fronto-ocular zone. The exact anatomical pathways from back to front have not as yet been elaborated, which suggests that such pain radiation is due to a cervical-trigeminal reflex at a brainstem level.

The production of herpes zoster in the patient after occipital neurectomy proves, at least to my satisfaction, that a branch of the second cervical nerve root and its occipital extension *must* supply the forehead area directly. Indeed, all of the patients of this series suffering from headaches of incontrovertibly major organic causes did complain of fronto-ocular radiation or onset of pain frontally. Absence of this component of the syndrome throws suspicion upon the accuracy of the diagnosis.

Auopsy of the carcinoma of the lung patient referred to discolosed metastasis to the *left* half of the cerebellum. Therefore, right occipital neuralgia could not have been a symptom of intracranial expansile irritation; and direct nerve infiltration was revealed histologically, as noted.

In a few patients, headache of a different type recurred after surgery, but it was so clearly differentiated by the individual that he did not become disappointed when he considered the benefit obtained by neurectomy.

Anatomy, Pathology of Occipital Neuralgia

Occipital nerve resection has been described in neurosurgical practice for many years. The definitive article on the subject of the surgical therapy of occipital neuralgia appeared in 1949, when Hunter and Mayfield discussed their experience with 11 patients and described relevant anatomical and pathogenetical considerations in this syndrome.[1]

The sensory component of the first cervical nerve root is meager. The roots of the third cervical nerve root are not subject to the compression of motion since they are well protected in their bony canals. But the sensory components of the second cervical nerve roots, the chief and only constituents of the greater occipital nerves, pass outwards or come in from between the posterior arches of the atlas and axis. Potentially, they are subject to traumatism, because of the forward-backward snapping of these structures or rotation of the head takes place between the atlas and axis, not between the atlas and the skull. These nerve roots are also vulnerable because they have no carapacial protection posteriorly, as do their homologues above and below.

The causative agents of occipital neuralgia in their order of importance are trauma, arthritis, and other conditions, such as inflammation or other tissue change which result in "nerve pinching." A notable and fascinating exception is thrombosis of one or more components of the vertebral-basilar arterial system. This type of thrombosis announces its presence by pain over the mastoid process on the same side as occlusion. Persistence of such pain in two patients in this series became a chief complaint.

In these cases, relief by occipital neurectomy is classic proof of "referred pain"—branches of the same second cervical sensory nerve root supplying the vessel and cutaneomuscular external fields.

Histological examination of the nerve specimens that were removed from the patients, disclosed neuromas in four, and infiltration by carcinoma in the one patient, which was described. The remainder of the biopsies appeared normal.

Surgical Considerations

Hunter and Mayfield divided the second cervical nerve roots intraspinally in some patients, and avulsed the greater occipital nerves in others.[1] In all of the patients reported here, avulsing external neurectomy of the greater occipital nerve or nerves was performed. The procedure proved to be adequate, and such surgery is simple, indeed, by comparison with intraspinal rhizotomy. The latter not only requires cervical laminectomy in the seated position, but may be and has been followed by the "progressive confusional syndrome", a formidable psychiatric complication also known to be the result of acute cervical traumatic conditions, such as a broken neck.

One or more linear incisions are made over the palpable grooves of the greater occipital nerves, which are equidistant between the external occipital protuberance and the mastoid process on either side of the posterior skull. If anatomical peculiarities are present, such as a short, fat neck, a transverse incision extending from mastoid tip to mastoid tip may be made instead, as in the performance of a cerebellar craniectomy. (Two detergent shampoos prior to skin preparation may obviate the necessity of shaving the scalp.) When the greater occipital nerve is glued to the occipital artery, which is very tortuous, hemorrhaging occurs sometimes. If it does, it can be controlled by electrocoagulation (Fig. 1).

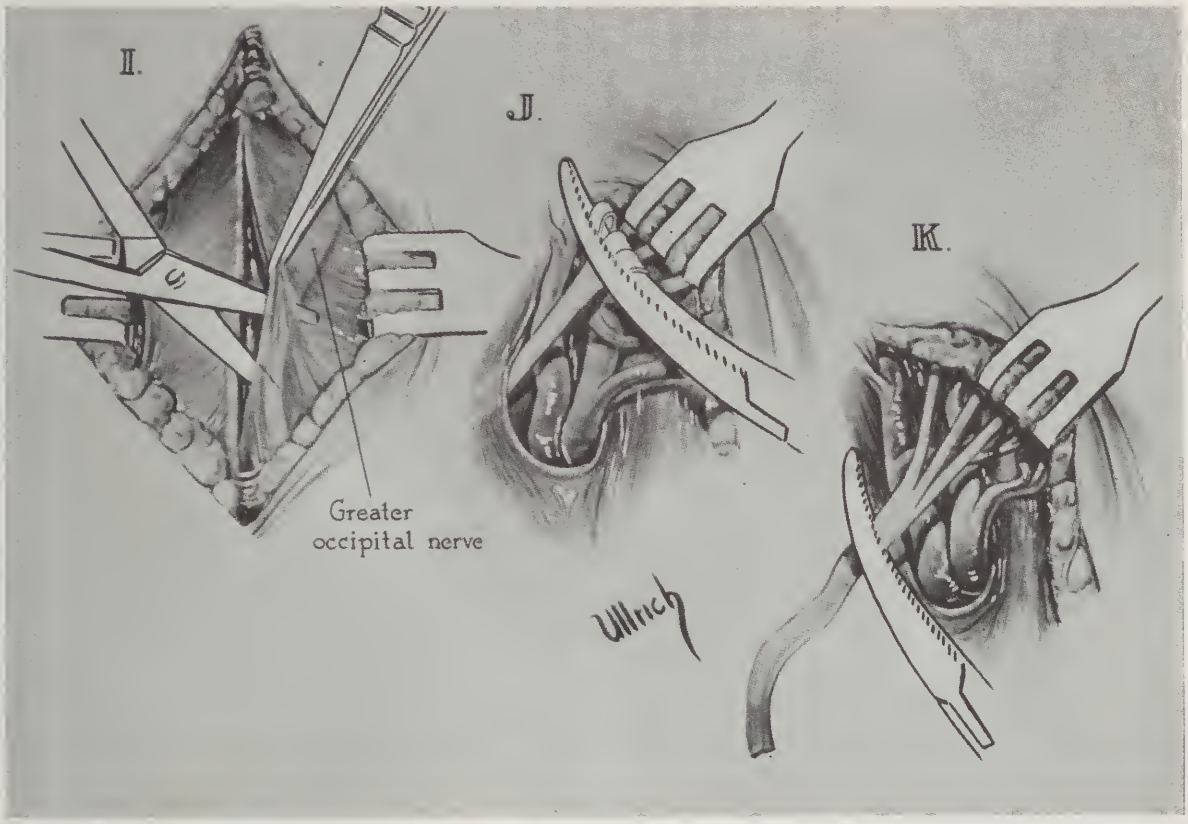


Fig. 1. Details of Occipital Neurectomy. (From Poppen, James L., "An Atlas of Neurosurgical Techniques", Published by W. B. Saunders Company, Philadelphia and London, 1960. Reproduced with permission of the Publisher.)

Experience demonstrates that it is not necessary to remove the minor occipital nerves, in addition to major occipital neurectomy in order to obtain a favorable result. There is, however, no reason not to take both sets of nerves if convenient. In one patient, minor occipital neurectomy had to be included since neuralgic pain was the consequence of previous mastoidectomy.

As much of the occipital nerves is avulsed as possible by twisting and pulling upwards on the axonal bundle with a hemostat. Sometimes, the length of nerve obtained gives pause to the surgeon who entertains the possibility of intraspinal cord damage, but this has never occurred in the experience of anyone, to the best of my knowledge. The occipital arteries may be divided (but not avulsed!) if pulsation is a part of the patient's chief complaint.

If regeneration of nerves after two to four years causes symptoms to recur, secondary surgery will be as effective as the primary procedure. (Reoperation was necessary in the patient whose pain resulted from a mastoidectomy scar.)

Loss of sensation after surgery is confined to the back of the head. At first, the area of numbness is extensive, but it soon contracts to a small island on one or both sides. Sensory limitation has not been considered to be troublesome by patients relieved of headache. Only two hospital days are usually required for surgical treatment. Stitches are removed in the office on the fifth postoperative day.

Diagnosis, Selection of Cases

Rather than rely upon psychiatric clearance in the selection of patiens for neurectomy to relieve occipital neuralgia, a positive diagnostic conformity is preferable. It is hard, if not impossible, to find anyone who does not have "problems."

In order to have a favorable prospect for occipital nerve surgery, the following criteria must be fulfilled in whole or in part: Typical pain must be reproduced by pressing over the homolateral occipital neurovascular bundle or by compressing the head or the neck with the vertex of the head tilted to the

painful side. The pain must radiate from the suboccipital or occipital area to the ipsilateral forehead or eye, or vice versa. There must be an adequate history of trauma, clearcut evidence of cervical arthritis, painful intracranial arterial thrombosis, or another competent producing organic cause of pain. Neurological signs of a valid conformatory type, such as loss of sensation or hyperalgesia of the skin area, presumably caused by the affected nerve must be observed. Nerve block with xylocaine or another comparable anesthetic must relieve pain, if it is said to be present at the time of injection. Such a nerve block was temporarily effective in all of the patients in this series, but was never effective permanently. It is extremely questionable that it ever is effective in a case of true occipital neuralgia of organic cause.

With reference to trauma, liabiility-favored, rear-end automobile collisions, with ensuing litigation still in process, must be weighed accordingly in deciding whether or not physical injury resulting from the accident is the principal cause of occipital neuralgia.

Needless to say, no patient in this series, who complained of pain in the back of the head, possibly originating within the cranium, was treated by peripheral occipital neurectomy until exhaustive diagnostic workup was completed, and was found to be normal. This included spinal puncture, EEG, x-rays of the skull, intracranial angiography, intracranial air studies, and cervical myelography which were carried out as and when conditions necessitated. All of the patients in this series were studied by one or more of these adjuvant techniques, in addition to clinical neurological examination.

Summary

Occipital neuralgia is a syndrome in which compression, injury, or other irritation of the occipital nerves on one or both sides of the head cause severe pain, which originates in the upper cervical and posterior parts of the cranium and radiates to the ipsilateral eye and forehead or vice versa.

A variety of symptoms such as, trauma and cervical arthritis are prominent and can be causative factors.

If the condition is physical in origin and evidences of an intracranial source of symptoms are lacking, occipital neurectomy, unilateral or bilateral as indicated, can produce long lasting relief from pain. Intraspinal rhizotomy was not necessary in any of the patients in the series reported here.

Careful analysis of presumably nonspecific or inorganic headache problems will reveal many patients who can benefit from this simple and curative operative procedure.

———0———

REFERENCE

1. Hunter, C. R., and Mayfield, S. H.: Role of the Upper Cervical Nerve Roots in the Production of Pain in the Head, *Am J Surg* **78:**743-751, November, 1949.

ANNUAL REPORTS
1968



MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

ANNUAL REPORTS
TO THE HOUSE OF DELEGATES

APRIL 1969

INDEX TO REPORTS OF OFFICERS AND COMMITTEES

Bylaws 71
Contractual Arrangements 75
Council & Executive Committee 69
Curator 75
Delegates to the AMA 75
Emotional Health 79
Executive Secretary 71
Finance 80
Insurance Trust 80
Journal 80
Library & History, Finney Fund 81
Maryland Medical Political Action 83
Maryland Medical Service, Inc. Board of Trustees 82
Medical Annals of Maryland 82
Membership 83
Policy and Planning 83
Postgraduate Education, Preventive Medicine, & Public Health 84
Program and Arrangements 88
Public Relations 89
Secretary 71
Treasurer 93
University of Maryland Chapter, Student AMA 89
Woman's Auxiliary 91

REPORTS

To The House of Delegates

The material contained in these Reports is informational only and does not reflect Faculty policy until such time as action is taken on them by the House of Delegates.

Recommendations and items contained herein are only up **for consideration** at this time.

COUNCIL AND EXECUTIVE COMMITTEE

Mr. President and Members of the House of Delegates:

The Council met at its regular stated intervals during the 1968-1969 year, as did the Executive Committee. Items of the most importance, and a summary of actions taken by both of these groups, are as follows:

Council: March 28, 1968;

PROFESSIONAL MEDICAL SERVICES COMMITTEE RECOMMENDATION ON PAYMENTS FOR MEDICAID INPATIENT AND OUTPATIENT SERVICES, EXCLUDING HOME AND OFFICE VISITS

The following recommendation was adopted by the Council:

> That payment for Title 19 patients for professional services rendered patients in inpatient and in outpatient departments of hospitals be made on the basis of Usual, Reasonable and Customary fees until such time as the funds appropriated for these purposes are depleted.
>
> It is expected that services will not be withheld by physicians when such a point is reached. However, it should be understood that physicians will continue to submit bills, even though payment may not be received for those services rendered to patients who have been certified by the State agency as being eligible for medical care services for whom the State under its Medical Assistance Program has assumed full financial responsibility.

It is to be made clear that this adoption of a position does not involve home and office care under the Title 19 program.

POLICY ON USE OF MARYLAND TUBERCULOSIS ASSOCIATION AND STATE HEALTH DEPARTMENT X-RAY SERVICES

The following recommendation of the Occupational Health Committee was adopted by the Council:

> The Medical and Chirurgical Faculty of Maryland supports the principle that industry, requiring pre-employment chest X-rays, should be encouraged to contract with a private radiologist whenever possible. The Health Department and the Maryland Tuberculosis Association should discourage the use of their facilities by industry for pre-employment X-rays where it is felt that such an arrangement with a private radiologist is feasible.

PARTICIPATION IN MEDICAID PROGRAM

A subcommittee named by the Council chairman to prepare a statement on the Faculty's participation in the Medicaid program made its report which, after discussion, an amendment was adopted as follows:

> The Council of the Medical and Chirurgical Faculty of the State of Maryland, at its January 1968 meeting, stated it would clarify at its meeting in March, 1968, its position in regard to the Medicaid program, after the conclusion of the 1968 General Assembly session.
>
> Inasmuch as the Governor and the Legislature have failed to meet their obligations to those citizens for whom the state has assumed financial responsibility, by not appropriating sufficient funds to provide for their medical care, the Council cannot endorse either the present or proposed Medicaid program.

Following adoption of this action and general discussion, it was agreed that appropriate Faculty committees meet with their counterpart groups of the dental and pharmaceutical societies, as well as any others, for the purpose of preparing for transmission to the Governor and members of the Ad Hoc Health Planning Committee, comments on the initial report of the Ad Hoc Health Planning Committee to the Governor.

Executive Committee, March 9, 1968:

CHIROPRACTOR ACTIVITY

The Executive Committee voted to recommend to the Council that the following Mediation Committee recommendations be approved:

(a) The Faculty obtain an injunction to prohibit the use of term "physician" by Chiropractors
(b) Obtain an injunction to prohibit Chiropractors using the technique of "testing" to mislead persons as to scope of their practice

It is understood that legal counsel will be present for this discussion so as to explain the mechanisms of this proposal, as well as possible cost, etc.

Council, June 6, 1968:

INJUNCTION AGAINST USE OF TERM "CHIROPRACTIC PHYSICIAN"

The Executive Committee had recommended endorsement of the Mediation Committee's proposal that the Faculty proceed in obtaining an injunction against the use of the term "Chiropractic Physician" by some Chiropractors.

Counsel explained that his fee would be charged on the basis of his court appearances, a rate of $150 per day, as well as any other *cost* incurred in connection with preparing and serving of the papers. He estimated this to be in the neighborhood of $100. The legal

research, etc., would be part of the services rendered under his retainer.

The Council voted unanimously that Mr. King be empowered to proceed along the lines of his outline and the funds be expended to accomplish this purpose.

PROHIBITION OF CHIROPRACTORS MISLEADING THE PUBLIC BY TECHNIQUE OF "TESTING"

Some discussion ensued in this connection. This was also a recommendation of the Executive Committee, as suggested by the Mediation Committee.

The Council voted that Counsel be empowered to investigate the possibility of obtaining injunctive proceedings in this area, if after exploration it was determined that it would be proper to do so.

The question was raised regarding liaison between the Board of Medical Examiners and the Faculty and suggested the possibility of having a Board member serve on or attend Council meetings. It was agreed this was no particular problem at this time because both Drs. Cohen and Mech are on the Board and the Council. This could be discussed at a future date, if necessary, and any necessary changes made in the bylaws.

FORMULARY SYSTEM FOR MEDICAID PATIENTS

The Council discussed at some length the question of approval of the principle of publication of a "Formulary System" for physician prescribing under the Title 19 program in Maryland. It was brought out that the Pennsylvania program was under consideration for adoption in Maryland. Adoption of this program would result in substantial financial savings in printing and publication costs, and staff time for both development of a formulary system as well as computer programming time.

It was then voted that the Council endorse the principle of a formulary system for use of physicians in prescribing medication for Medicaid patients—with the understanding that it is an "open" formulary, and that it will be developed and changed, as necessary, in full cooperation with the Medical and Chirurgical Faculty.

FACULTY REPRESENTATIVE ON NEWLY FORMED MEDICAL TISSUE DONATION COMMITTEE

The circumstances leading to the formation of this new group were outlined. The Faculty had acted as a catalyst to bring all interested parties together for the purpose of discussing the following:

> Providing a central registry where potential donors could (a) receive information on all aspects of tissue donation and (b) list themselves as having indicated their desires with respect to such tissue donations. In addition, the registry could list needs and requirements of those persons or institutions engaged in transplant or research activities in these areas; as well as conduct educational efforts in hospitals so that antemortem permission could be obtained for persons who were near death, instead of endeavoring to obtain postmortem permission from relatives.

The Council indicated its support of this concept and then voted to designate Russell S. Fisher, MD, as its representative. The Faculty designee would serve as chairman of the committee.

Executive Committee, July 18, 1968:

CONTINUED PURSUIT OF INJUNCTION PROHIBITING USE OF TERM "CHIROPRACTIC PHYSICIAN"

Counsel stated that there were some legal questions being raised in connection with this action of the Council and he would like some direction from the Executive Committee in this regard.

The main question was one of strategy. He believed that it would be better strategy to wait until the Medical Practice Act Revisions become law and then pursue this question.

In the proposed revisions, a clear definition of the term "physician" appears. This would strengthen the hands of the Faculty in this area, if it is approved by the General Assembly.

The Executive Committee concurred in delaying any further action on this subject until after the 1969 General Assembly meets.

Executive Committee, September 5, 1968:

ANESTHESIA STUDY GROUP ON STATE-WIDE BASIS

It is proposed by the Maryland Society of Anesthesiologists that the current study of anesthesia deaths carried out jointly by the Baltimore City Health Department and the Baltimore City Medical Society be expanded to a state-wide project, similar to the maternal and child mortality studies.

Approval of the Faculty is sought to make this a state-wide project. The Executive Committee approved extension of this to a state-wide basis.

Executive Committee, October 10, 1968:

WORKMEN'S COMPENSATION COMMISSION, PAYMENT OF USUAL, CUSTOMARY AND REASONABLE FEES

Mr. Sargeant reported that the Faculty was granted an informal hearing before the full commission on September 19, 1968; and following this, it had submitted a proposal that such be the policy of the Commission, with the understanding that those physicians desirous of treating Workmen's Compensation cases list their Usual, Customary and Reasonable Fees with the Commission. This would then permit the carriers to have some guidelines to use in making payment on bills submitted.

Since then, the physicians who treat between 60-70% of such cases in the Baltimore area held a meeting and have agreed to abide by the Fee Guide issued by the Faculty in 1966, and to submit a schedule for home and office visits under which they will operate. It has been suggested the Faculty inform the Commissioner of this information, but the Executive Committee decided that those individuals wishing to do so, jointly sign a letter to the Commission outlining their proposal.

Executive Committee, November 14, 1968:

MULTIPHASIC SCREENING

The chairman presented an outline of what Multiphasic

Screening covers. He also discussed a meeting that had been held with representatives of the Bendix Corporation. After considerable discussion and questions and answers, the Council adopted the following:

The Council authorizes the Ad Hoc Committee on Multiphasic Screening to continue its work with the Bendix Corporation, and expresses its interest in this program with the provision that the Council be kept fully informed so that it can approve or disapprove each recommendation.

The Council also requests that all Specialty Groups involved be kept informed of this activity and be invited to participate in the deliberations of the ad hoc committee.

After adoption of that motion, the following additional motion was adopted:

That the Ad Hoc Committee be recommended to consider other alternatives to sponsorship of the Multiphasic Screening Program.

During these deliberations it was emphasized that no corporate structure would be used to employ physicians; Bendix would be involved in the operation of the technical aspects of the program only.

DIRECT TELEPHONE LINES

On recommendation of the Pharmacy Liaison Subcommittee and the Mediation Committee, The Council adopted the following motion:

The Medical and Chirurgical Faculty of the State of Maryland opposes direct telephone lines between a physician and a pharmacy.

It is understood that the Maryland Pharmaceutical Association and the C & P Telephone Company will be advised of this policy decision.

In addition to these actions, the Council and Executive Committee made recommendations for appointments to various boards, committees, governing bodies and agencies of the state government. The Council also ratified a total of 38 requests for legal defense and notes that the number of requests for this service is increasing at an astronomical rate.

Recommendations for Emeritus Membership is made for the following, all at the request of the component society indicated:

Baltimore City Medical Society:
Jacob R. Jensen, MD
Leo Kanner, MD
S. Demarco, MD
C. W. Peake, MD
H. F. Bongardt, MD

Carroll County Medical Society:
Elizabeth Reese Wilkens, MD

Montgomery County Medical Society:
John N. Andrews, MD

Respectfully submitted,
JOHN F. SCHAEFER, MD, *Chairman*

SECRETARY

Mr. President and Members of the House of Delegates:

The position of Faculty Secretary carries with it many responsibilities, such as supervising the proper handling of the correspondence, and scheduling of meetings throughout the year. More than 500 such meetings were scheduled and held during the past Faculty year.

Minutes of various committee, subcommittee and other sessions were prepared, meeting notices mailed and permanent records maintained of all Faculty activities. Complete files on all such material are available at the Faculty office.

Respectfully submitted,
WILLIAM A. PILLSBURY, MD, *Secretary*

EXECUTIVE SECRETARY

Mr. President and Members of the House of Delegates:

The work of the Executive Secretary and the Staff is reflected in the activities of the various Faculty Committees. What is not indicated, however, is the volume of individual telephone calls, personal visits and visits to component medical societies throughout the State that do much to knit the membership together and make membership in the Faculty meaningful.

During the past year, meetings with my counterparts in other professional organizations in the state have been instituted. These are informal and are held on an irregular basis. Mutual experiences and solutions to problems are discussed.

Sessions with full and part-time executive secretaries of component societies were continued. This does much to cement the bonds of friendship between the state and many of its components. Not only are components made aware of our planning, but they are also aware of the vital and tremendous role the Faculty plays in contemporary affairs today.

Respectfully submitted,
JOHN SARGEANT, *Executive Secretary*

BYLAWS COMMITTEE

Mr. President and Members of the House Delegates:

The Bylaws Committee submits the following proposed changes in the Faculty's Bylaws:

1. Upgrading of the present Subcommittee on Medicine and Religion to a full Faculty committee:

The reasons given for this proposed bylaw change are that increasing moral and religious problems are foreseen with the expansion of heart and other tissue transplants, as well as determinations as to time of death. In addition, Medical and Theological Schools are considering seriously the expansion of their curricula to include Medical and Religious subjects.

Amend Article XI, by inserting new section 13 to read as follows:

Section 13. A Committee on Medicine and Religion shall be appointed by the President to consist of not less than six members. It shall be charged with maintaining liaison and effective lines of communication between physicians and clergymen leading to the most effective care and treatment of the patient and his family. It shall also endeavor to assist medical schools

and nursing schools in their educational endeavors, and shall be available to theological seminaries for similar assistance—all within the areas of medicine and religion combined.

2. At the present time, there is a conflict in the Bylaws dealing with the provision of legal defense in cases of alleged malpractice. Article III, Section 5, reads:

"Any member entitled to Physicians' Defense shall forfeit that right if his dues were not paid to his component society by January 31, in the year in which the alleged malpractice occurred, provided that new members admitted after January 31, shall be entitled to physicians' defense for alleged acts committed after the date their membership application is filed with the component society secretary."

Article VII, Section 2, reads, in part:

"The Council shall have all power and authority over the affairs of the House of Delegates, except modifying any action taken by the House of Delegates, and shall have power to: . . . authorize physicians' defense. . . ."

Article XII, Section 2 reads:

"On a majority vote, the Council may authorize physicians' defense and the matter shall be referred to an attorney-at-law retained by the Council for a term of one year."

Article III, Section 5, indicates that the physician *has the right* to physicians' defense, provided he meets the dues payment requirement. It does not give the Council discretion to determine whether or not this should be granted, although the other sections, Article VII, Section 2; and Article XII, Section 2, both seem to indicate there is discretionary power to deny or grant such defense.

In actuality, however, all legal defense cases are reported to the Council, which automatically ratifies the granting of defense. In order that the procedural activity be simplified, it is suggested that the following bylaw change be adopted:

Amend Article VII, Section 2, by striking out the following:

"authorize physicians' defense"

Amend Article XII, Section 1, by striking out:

"to the Council"

Amend Article XII, Section 2, by striking out:

"On a majority vote, the Council may authorize physicians' defense and the matter"

and inserting:

"Physicians' Defense Cases"

3. Forty-Year Members are not subject to dues. Frequently, such members may move from the State when they retire from active practice. There is no provision for retention of this status of membership. Presently, such members are required to be members of component societies in Maryland. They would, therefore, have to change to Emeritus Status or Affiliate Status.

It is, therefore, recommended that Forty-Year members be permitted to retain this status if they move outside of Maryland and the following bylaw amendment is recommended for adoption:

Amend Article II, Section 5, by adding the following new sentence:

"Forty-Year Members who have this status prior to removing from the State of Maryland may continue to hold this type of membership after their removal."

4. In accordance with the Semiannual Report of the Bylaws Committee, we are pleased to present the following bylaw amendment, in connection with the composition of the Faculty's Council:

Substitute for Article IV, Section 3, the following new section which reads as follows:

Section 3. One third of the COUNCILORS provided below shall be elected annually by the House of Delegates from among the active members of component societies comprising the following districts:

(a) Western District: Allegany, Garrett, Carroll, Frederick and Washington counties

(b) Eastern District: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester counties

(c) Central District: Baltimore city, Baltimore and Harford counties

(d) Southern District: Anne Arundel, Calvert, Charles, Howard and St. Mary's counties

(e) South Central District: Montgomery and Prince George's counties

Representation shall be on the basis of one Councilor from each district, plus one additional Councilor for each 200 active and Forty-Year Members in good standing on December 31 each year.

The adoption of this bylaw change results in Councilors for each district as follows:

Central District	1896 Members	11 Councilors
Eastern District	192 Members	2 Councilors
South Central District	728 Members	5 Councilors
Southern District	173 Members	2 Councilors
Western District	294 Members	2 Councilors

There is no change in the total number of councilors now on the Council.

PROPOSED BYLAW AMENDMENTS FOR PRESENTATION TO THE HOUSE OF DELEGATES APRIL, 1969

Amend Article XI, by adding new Section 13:

OLD	*NEW*
(No such section, except included as an optional Subcommittee appointment of Liaison Committee)	"Section 13. A Committee on Medicine and Religion shall be appointed by the President to consist of not less than six members. It shall be charged with maintaining liaison

and effective lines of communication between physicians and clergymen, leading to the most effective care and treatment of the patient and his family. It shall endeavor to assist medical schools and nursing schools in their educational endeavors, and shall be available to theological seminaries for similar assistance—all within the areas of medicine and religion combined."

Amend Article VII, Section 2 by striking out the phrase, "authorize physicians' defense."

OLD

Section 2. The Council shall have all power and authority over the affairs of the House of Delegates, except that of modifying any action taken by the House of Delegates, and shall have power to: (1) issue charters to component societies; (2) recommend assessments; (3) remit a member's dues or assessment; (4) approve the budget; (5) appoint one or more assistant secretaries or assistant treasurers; (6) fill vacancies among the elective officers and those appointed by it; (7) fix the date and place of General Meetings; (8) **(authorize physicians' defense);** (9) appoint an Editor of the MARYLAND STATE MEDICAL JOURNAL for a term of three years or until his successor is appointed; (10) set the amount of bond on the Treasurer, the premium to be paid by the Faculty; (11) retain counsel to the Faculty for a one-year period; and (12) select independent certified accountants to audit the Treasurer's accounts and report to the annual session of the House of Delegates.

NEW

Section 2. The Council shall have all power and authority over the affairs of the House of Delegates, except that of modifying any action taken by the House of Delegates, and shall have power to: (1) issue charters to component societies; (2) recommend assessments; (3) remit a member's dues or assessment; (4) approve the budget; (5) appoint one or more assistant secretaries or assistant treasurers; (6) fill vacancies among the elective officers and those appointed by it; (7) fix the date and place of General Meetings; (8) appoint an Editor of the MARYLAND STATE MEDICAL JOURNAL for a term of three years or until his successor is appointed; (9) set the amount of bond on the Treasurer, the premium to be paid by the Faculty; (10) retain counsel to the Faculty for a one-year period; and (11) select independent certified accountants to audit the Treasurer's accounts and report to the annual session of the House of Delegates.

Amend Article XII, Section 1, by striking out the words, "to the Council"

OLD

Section 1. Any qualified member who is the subject of a civil claim or suit for alleged malpractice, desiring to avail himself of the provisions of this Article, shall immediately make written request **(to the Council)** for physicians' defense setting forth a complete history of the case, the services rendered and his connection or relationship to the complainant.

NEW

Section 1. Any qualified member who is the subject of a civil claim or suit for alleged malpractice, desiring to avail himself of the provisions of this Article, shall immediately make written request for physicians' defense setting forth a complete history of the case, the services rendered and his connection or relationship to the complainant.

Amend Article XII, Section 2 by striking out the words, "On a majority vote, the Council may authorize physicians' defense and the matter" and inserting, therefore, the following: "Physicians' Defense Cases"

OLD

Section 2. **(On a majority vote, the Council may authorize physicians' defense and the matter)** shall be referred to an attorney-at-law retained by the Council for a term of one year.

NEW

Section 2. Physicians' Defense Cases shall be referred to an attorney-at-law retained by the Council for a term of one year.

Amend Article II, Section 5, by adding the following new sentence: "Forty-year Members who have this status prior to removing from the State of Maryland may continue to hold this type of membership after their removal."

OLD

Section 5. *FORTY-YEAR MEMBERS* shall consist of the active members in good standing of all component societies who have been active members for forty years or more. They shall have the rights accruing to active members.

NEW

Section 5. *FORTY-YEAR MEMBERS* shall consist of the active members in good standing of all component societies who have been active members for forty years or more. They shall have the rights accruing to active members. **Forty-year Members who have this status prior to removing from the State of Maryland may continue to hold this type of membership after their removal.**

Substitute for Article IV, Section 3, the following new section which reads as follows:

Section 3. One third of the COUNCILORS provided below shall be elected annually by the House of Delegates from among the active members of component societies comprising the following districts:

(a) Western District: Allegany, Garrett, Carroll, Frederick and Washington counties

(b) Eastern District: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester counties

(c) Central District: Baltimore city, Baltimore and Harford counties

(d) Southern District: Anne Arundel, Calvert, Howard and St. Mary's counties

(e) South Central District: Montgomery and Prince George's counties

Representation shall be on the basis of one Councilor for each district, plus one additional councilor for each 200 Active and Forty-Year Members in good standing on December 31 each year.

OLD

Section 3. One third of the *COUNCILORS* provided below shall be elected annually by the House of Delegates from among the active members of constituent societies comprising the following districts:

(a) Western District: Allegany, Garrett, Carroll, Frederick and Washington counties; **two councilors.**

(b) Eastern District: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester counties; **two councilors.**

(c) Central District: Baltimore city, Baltimore and Harford counties; **eleven councilors including at least eight from Baltimore city, two from Baltimore County and one at large.**

(d) Southern District: Anne Arundel, Calvert, Charles, Howard and St. Mary's counties; **two councilors.**

(e) South Central District: Montgomery and Prince George's counties; **five councilors; three from Montgomery County and two from Prince George's County.**

NEW

Section 3. One third of the *COUNCILORS* provided below shall be elected annually by the House of Delegates from among the active members of component societies comprising the following districts:

(a) Western District: Allegany, Garrett, Carroll, Frederick and Washington counties.

(b) Eastern District: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester counties.

(c) Central District: Baltimore city, Baltimore and Harford counties.

(d) Southern District: Anne Arundel, Calvert, Charles, Howard and St. Mary's counties.

(e) South Central District: Montgomery and Prince George's counties.

Representation shall be on the basis of one Councilor from each District, plus one additional councilor for each 200 Active and Forty-Year Members in good standing on December 31 of each year.

AS OF DECEMBER 31, 1968			*COUNCIL MEMBERSHIP*	
	NO. OF MEMBERS	*TOTAL*	*Present*	*Proposed*
CENTRAL DISTRICT				
Baltimore City	1,558			
Baltimore County	287			
Harford County	51	1896	11	11
EASTERN DISTRICT				
Caroline County	7			
Cecil County	23			
Dorchester County	19			
Kent County	13			
Queen Anne's County	4			
Somerset County	7			
Talbot County	37			
Wicomico County	75			
Worcester County	7	192	2	2
SOUTH CENTRAL DISTRICT				
Montgomery County	516			
Prince George's County	212	728	5	5
SOUTHERN DISTRICT				
Anne Arundel County	120			
Calvert County	7			
Charles County	10			
Howard County	18			
St. Mary's County	18	173	2	2
WESTERN DISTRICT				
Allegany County	86			
Carroll County	47			
Frederick County	62			
Garrett County	5			
Washington County	94	294	2	2

COMMITTEE ON CONTRACTUAL ARRANGEMENTS

Mr. President and Members of the House of Delegates:

No meetings of this group were held during the year. No complaints or requests were received and no problems arose that would involve the services of this committee.

Respectfully submitted,

J. Howard Franz, MD, *Chairman*
Robert Z. Berry, MD
Stanley J. Bociek, MD
Theodore Feldberg, MD
Paul F. Guerin, MD
Theodore Kardash, MD
John G. Lyons, MD
William J. McClafferty, MD
Elliott Michelson, MD
Thaddeus E. Prout, MD
Guy M. Reeser, Jr., MD
Albert Shapiro, MD
Charles E. Silberstein, MD
Henry H. Startzman, Jr., MD
Henry B. Wilson, MD
William A. Niermann, MD
James W. Smyth, MD

CURATOR

Mr. President and Members of the House of Delegates:

It gives me great pleasure to advise that donations of material and other equipment are continuing to be given to the Faculty, adding to our memorabilia.

During the last year, the following items have been received for the Faculty's collection. In each case, the donor has been suitably thanked, and the item has been recorded in the accession records of the Faculty. In some cases, the piece has been adequately displayed in the Faculty building for all to view.

Framed oil painting of Albert E. Goldstein, MD, a gift from his wife.

Suction machine, property of Moses Raskin, MD, a gift from his family.

Framed photographic portrait of Caleb Winslow, MD, a gift from his grandson, Mr. Caleb Winslow.

Doctorate robes, property of Walter D. Wise, MD, and Julius Friedenwald, MD, a gift from Mr. William McMillan, stepson of Dr. Wise.

As authorized by the House of Delegates, portraits are being restored and maintained in good condition. The sum of $500 per year is allocated for this purpose.

Respectfully submitted,
E. David Weinberg, MD

DELEGATES TO THE AMA HOUSE OF DELEGATES CLINICAL SESSION, DECEMBER 1-4, 1968, MIAMI BEACH, FLORIDA

Mr. President and Members of the House of Delegates:

The Faculty's three delegates to the AMA Clinical Session, held December 1-4, 1968, in Miami Beach, Fla., attended each session of the House of Delegates. In addition, the Senior Alternate Delegate and the Executive Secretary also attended each of these sessions. Assignments were made to the various Reference Committee hearings, so that full knowledge and discussion could take place in connection with all matters coming before the House. The resolution submitted by the Maryland Delegation (Resolution #5, Admission of Doctors of Osteopathy to full Active Membership in the AMA) was adopted by the House of Delegates. An appropriate bylaw amendment will be acted upon at the Annual Session in July 1969, in New York city. Actions of the House of Delegates included the following:

Discrimination

The Council on Constitution and Bylaws presented wording for the anti-discrimination amendments in response to the House's wishes expressed at the Annual Convention in June 1968.

The over-all statement on discrimination was added as a new Section 3 of the bylaws, Chapter I:

> Section 3—Discrimination in Membership
> Membership in the American Medical Association or in any of its constituent associations shall not be denied or abridged on account of color, creed, race, religion, or ethnic origin.

Provision for disciplinary action was provided by adding this sentence to Chapter XI, Section 11, (D) (7):

> If the Council determines that the allegations (of discrimination against physician applicants for membership) are indeed true, it shall admonish, censure, or, in the event or repeated violations, recommend to the House of Delegates that the state association involved be declared to be no longer a constituent member of the American Medical Association.

Osteopathy

The House adopted a Board report stating these objectives with respect to osteopaths:

To "assure the provision of the best possible health care to the American people; make available to students and graduates in osteopathy, education of the same high standards as prevail in undergraduate, graduate, and continuing educational programs in medicine; provide avenues whereby qualified osteopaths may be assimilated into the mainstream of medicine."

To achieve those objectives, the AMA recommends that each school of osteopathy improve its teaching program by strengthening its faculty and improving its facilities and resources; invites schools of osteopathy and their accrediting agencies to consult with the AMA and the Association of American Medical Colleges; suggests that accredited hospitals may accept qualified osteopaths on medical staffs; suggests that medical specialty boards may accept osteopaths for examination if they have com-

pleted AMA-approved internships and residency programs, and have met other regular requirements; requests that as specialty boards declare intent to permit examination of osteopathic graduates, appropriate AMA-approved residency programs be opened to qualified osteopathic graduates; suggests opening AMA-approved internships to qualified osteopathic graduates; recommends that determination of qualification be made at the level of the medical staff, the county medical society, or the review committees and boards having appropriate jurisdiction; and suggests that AMA, state and county societies and other affected organizations "may proceed to make such constitution and bylaw changes as are necessary to implement the foregoing."

The House also "suggests that each county and state medical society may accept qualified osteopaths as active members and thereby provide for their membership in the American Medical Association" and instructed the Council on Constitution and Bylaws to prepare "appropriate bylaw amendments so that qualified doctors of osteopathy may be admitted to full active membership" in the AMA. (This was the resolution submitted by the Maryland delegation.)

Awards

J. Arnold Bargen, MD, of Riverside, California, was chosen to receive the AMA Distinguished Service Award, which will be presented at the 1969 Annual Convention.

John D. Rockefeller, III, of New York, Chairman of the Board of the Rockefeller Foundation, was selected to receive the Citation of a Layman for Distinguished Service, also to be awarded at the Annual Convention in July 1969.

President's Report

Dwight L. Wilbur, MD, President, told the House that "Perhaps our greatest problem is that, in many ways, we in America have tried too hard and succeeded too well . . . We have progressed so far in so many areas that our people are impatient with the realities of human limitation. They are eager to instantly wipe out poverty, eliminate ignorance, sweep away ill will and violence, replace jealousies and hate with universal good will. Even the specter of death itself is by some considered a temporary and stubborn spite to mankind that will be mastered as soon as new organs are developed or transplanted and new drugs are synthesized."

President Wilbur listed five areas to which he believes the medical profession should give its greatest attention:

1. Making high-quality health care available for everyone in America at as reasonable a cost as possible.

2. Putting a rein on costs by avoiding hospitalizing any patient unless absolutely necessary; reducing the length of hospital stay to the essential minimum; using extended care facilities, nursing homes, and home-care services more often; stimulating prepayment mechanisms on a voluntary basis; supporting the principle of income tax credits for health insurance; keeping physicians' charges on a basis of usual, customary, and reasonable fees, with self-discipline and peer review; and encouraging wider use of reliable automated laboratory procedures, passing the cost benefits on to patients.

3. Developing more reasonable and more realistic expectations by the public.

4. Unifying the medical profession and maintaining constructive liaison between other groups.

5. Planning for an orderly and enhanced future. "We must," he said, "increasingly depend on the Board of Trustees to lead in planning and development for the future. . . . As an association, this is our greatest responsibility. The Board must increasingly be an informed board of strategy that looks ahead and advises the profession, the government, and the public regarding health measures."

The President closed his report by saying, "We are immersed in an epoch of change. We cannot hope to emerge from it as respected leaders unless we guide the course of change. . . . Our guidance in helping change all elements of society that affect the people's health is an orderly, balanced sequence which is the price of our continued esteem as a profession and an organization."

Organ Transplants

The House adopted a statement on heart transplantation which makes these five points:

1. The preservation of good medical practice demands that the evolution of therapy be orderly. "The staff of a hospital or medical center planning to initiate such a program should have: (1) adequate background in animal research so that experience is gained as to the problems, potentials, and limitations of cardiac transplantation; (2) experience in immunotherapy and an adequate source of antilymphocyte globulin of known quality; (3) a protocol of clinical research adequate to follow and evaluate the course of the patient."

2. Due regard for the welfare and safety of each individual patient is paramount.

3. Heart transplantation has brought certain medical, ethical and legal questions into critical focus. "Paramount among them is the determination of death. The right of the prospective donor to the best possible medical care—a right which his potential role as organ donor must not be allowed to abrogate—must remain sacred. The growing ability of medical science to maintain some form of biological function for prolonged periods adds to the difficulty of defining the point of irreversible dissolution.

"The cause of death must be evident and of irreversible type. The fact of death must be established by adequate, current and acceptable scientific evidence in the opinion of the physicians making the determination. The determination of death in organ donors must be made by no less than two physicians not associated with the surgical team performing the transplant."

4. The potential for heart transplantation, whatever that may prove to be by subsequent clinical experience, will be "severely limited by the shortage of potential organ donors. . . . Basic research into the causes of heart disease and of hypertensive vascular disease is . . . of vital importance, since the only ultimate solution to the problem of heart disease lies in its prevention."

5. "Human heart transplantation has been accompanied from the outset by a degree of public awareness and attention almost without parallel in medicine. . .

It is imperative, therefore, that the public be made fully aware of the potentialities and limitations of heart transplantation as those are currently understood and as that understanding is modified by subsequent experience. . . . Only by preserving public confidence in the judgment of the physician, can the orderly progress of medicine be maintained."

The House also approved the Uniform Anatomical Gift Act and urged each state medical association to give it careful consideration "with a view to seeking its adoption in its state." State associations were urged to consider carefully the provisions of the legislation and to make any necessary changes to accommodate their needs. The Uniform Act has been approved by the American Bar Association through the Liaison Committee to the ABA and the House supported cooperative efforts by state medical associations and state bar associations to secure prompt adoption of the legislation. (Maryland has already adopted an almost identical law.)

Health Care Costs and Financing

Following its similar action at the 1968 Annual Convention, the House again accepted for information the report of the Committee on Health Care Financing pertaining to the use of federal income tax credits for the purchase of health insurance and adopted a resolution that the AMA "vigorously promote the enactment of federal legislation which would translate the concept of income tax credits for health insurance premiums into law."

The House asked the Board of Trustees to devote sufficient staff, facilities and funds to develop an "effective program for immediate and on-going studies of health care costs" and to report the status of the program at the 1969 Annual Convention. The Board also was requested to expedite and expand existing programs and, "where necessary, develop new programs for the following purposes: (1) analysis of health care costs and expenditure data developed and reported by other sources; (2) definitions, reports and explanations of the several major categories of health care expenditures; and (3) dissemination of the data, findings and conclusions of such studies to constituent medical societies, news media and state and federal governmental authorities."

Recognizing that advertising and promotion of new Blue Shield programs providing broader benefits might be subject to misinterpretation by the public, the House resolved that "any references to 'paid-in-full' coverage clearly identify those services which are indeed covered on a 'paid-in-full" basis and also identify the circumstances under which those services must be rendered."

In two other actions, the House called on "all voluntary health insurance organizations to offer reinstatement of all contracts which were cancelled or converted because the insured individual was over age 65 and eligible for" medicare; and reaffirmed the AMA's belief that "the concept of voluntary health insurance is the most acceptable means of financing health care when applied in keeping with the principles of the American Medical Association."

Matters of Patient and Public Interest

The House adopted the Council on Medical Education's "Special Requirements for Residency Training in Family Practice" and resolved that the AMA "affirm the importance of providing appropriate recognition for family physicians through approval of a primary specialty board for family practice and that the Council on Medical Education be encouraged to continue its efforts with the American Academy of General Practice and the AMA Section on General Practice to achieve this goal."

In other actions, particularly aimed at patient care and public well-being, the House:

. . . Accepted for information a report that a portion of the Third National Congress on the Socio-Economics of Health Care would be devoted to solo practice.

. . . Adopted a report on the AMA's continuing concern with obesity treatment.

. . . Adopted a report stating that the AMA has proposed to the National Center for Health Statistics a meeting among concerned groups to review a revised certificate of live birth.

. . . Endorsed in principle the use of a multi-purpose health record form in providing medical examinations for young people.

. . . Resolved that the AMA "again urge its members to play a major role against cigarette smoking" and that the AMA "take a strong stand against smoking by every means at its command."

. . . Noted reports by "experts in recognized medical centers of new therapeutic uses of 'old' drugs which may be indicated in patients currently under the care of the physician" and resolved that the AMA discuss this problem with the Commissioner of Food and Drugs in an effort to enable the practicing physician to employ such new, life-saving therapy legally when indicated.

. . . Encouraged the American Association of State Highway Officials and the Federal Highway Administration to work toward the adoption of the International System of Highway Signs which avoids the use of language in order to make the visits of foreigners to the United States "as safe and pleasant as possible."

. . . Urged constituent societies in those states where existing laws do not permit minors to consent to treatment for venereal and other communicable diseases "to seek the enactment of such legislation." (Maryland already has such legislation; having taken the initiative on this subject over two years ago.)

Education

The House adopted a report of the Board of Trustees offering its comments (approval or suggested amendments) on many of the recommendations of the Report of the Citizens Commission on Graduate Medical Education. However, the Board pointed out that "it is neither possible nor desirable to make final recommendations . . . at this time on some of the more controversial portions of the report. These portions deserve further careful study and deliberation by all concerned individuals, institutions and organizations."

A program for formal recognition by the AMA of physicians who participate in continuing medical education was adopted, along with a proposal to fund the recognition award.

"A physician may, upon request," the report said, "receive the recognition award at the completion of three

years of graduate training in AMA-approved programs, or the equivalent in research activity or in educational programs leading to further advanced degrees in medical sciences."

Funding will include a registration fee of $5 for each physician who wishes to participate. The fee would cover the costs of printing, handling, mailing and processing the correspondence and certificates as well as the costs of initiating and maintaining the record system. Each physician would pay the registration fee only once in each three-year period.

The House recommended that the Medical Education for National Defense Program "be reinstituted at the earliest possible date; direction be the responsibility of the Department of Defense; adequate financial support be provided with appropriate safeguards to assure that funds will be used solely for the purposes of the program; and that such support be allocated to the medical schools on the basis of program merit."

And the House also encouraged the creation of continuing high quality service-career physicians "through specific support of existing medical school expansion to include selected, service career-oriented students."

Allied Health Personnel

The House agreed with the Council on Health Manpower regarding the need for physician prescription and supervision of all ancillary services provided in the hospital by adopting a Board of Trustees report on the utilization of paramedical personnel. In adopting the report, the House stated that "the medical staff should concern itself with contractual agreements between various allied health professionals and the hospital only insofar as, and to the extent that, such agreements tended to remove the provision of ancillary services from the prescription and supervision of the physician."

Another Board report adopted by the House, based on findings of the Council on Health Manpower, considered the phrase "related healing arts" as used in the declaration of purpose in PL 89-749. The report stated that "it is apparent that the context in which this term is used offers assurance that the patterns of medical practice in the country will not be altered by PL 89-749." Consequently, the Council recommended "that any definition of the term 'related healing arts' should be made at the state and local level because of the important variations in practice within the country."

The House adopted the Council on Medical Education's revision of "Essentials of Approved School of Medical Technology" and its "Essentials of an Accredited School of Radiation Therapy Technology."

In regard to nurses, the House resolved that "state and county medical societies be encouraged to study the problems relating to nursing education and to seek at the local level all available sources of financing support for hospital nursing schools" and that the AMA "take appropriate action in consultation with professional nurses' associations and the American Hospital Association to encourage increasing enrollment in diploma schools."

Medicine and the Government

The House accepted for information reports of the Council on Medical Service regarding neighborhood health centers under the Office of Economic Opportunity, Public Health Service, and Housing and Urban Development and Project Headstart.

In addition, the following resolutions were adopted by the House:

. . . That the AMA "seek to have Congress phase out Federal health care programs which overlap and reduplicate Medicaid."

. . . That PL 89-749 be amended to require that "a substantial percentage" of executive boards or councils "at all levels of planning—Federal, state and regional—both A and B agencies, be actively practicing private physicians nominated by organized medicine."

. . . That county and state medical associations, through the AMA, supply when requested, "the names and biographical data of physicians who are qualified, willing, and able to accept appointment in government service, full or part time."

. . . That the Board of Trustees "consider sponsorship of periodic conferences or workshops on public affairs for the continuing education and benefit of medical society leaders and physicians throughout the nation."

. . . That the AMA "exert every effort to bring about the elimination of unnecessary documentation of medical services by the physician, hospital and fiscal intermediary on Medicare and Medicaid patients."

. . . That all school administrative bodies be encouraged to consult with "competent medical authorities prior to initiating and conducting programs involving any medical aspects funded under the Elementary and Secondary School Act."

. . . That "physicians and their medical societies should strive to attain the adoption of established principles which are designed to provide the people of this nation with the highest quality of medical care" and that all physicians be reminded "that as free men and women they have no obligation to accept employment and remuneration under any conditions other than those arrived at by agreement between the physician and the recipient of his service."

Mostly of Internal (AMA) Interest

State and county medical societies were urged to establish uniform membership classifications based on AMA membership categories described in the bylaws. (Maryland has already done this.)

The Board of Trustees was asked to consider seriously recommending to the House that the 1976 Clinical Convention be held in Philadelphia as a part of the bicentennial celebration of the Declaration of Independence.

The House accepted for information a report that the Council on Medical Service has reconstituted its committee structure to provide for committees on Health Care Financing, Government Medical Services, and Community Health Care.

A report on the AMA-ERF and a special financial report on the Institute for Biomedical Research was adopted by the House, along with a resolution that a liaison committee of 10 members of the House "meet during the time of each convention of the House, or more often if necessary, with the President and Directors of the AMA-ERF and the Director of the Institute for Biomedical Research for review of current programs

of the AMA-ERF and consideration of suggestions for broadening the base of support for the AMA-ERF, and to report the results of such meetings to the House at each convention."

Dr. George W. Beadle, former president of the University of Chicago, was introduced to the House at the opening session, which took place on the day Dr. Beadle assumed directorship of the Institute.

A progress report on the management survey of the AMA, which is now under way, was adopted by the House. Also adopted was a resolution that "the Board of Trustees be requested to continue to observe closely the activities of the Division of Public Affairs since this division is newly formed with newly defined functions and activities; and . . . that the House of Delegates receive in advance a comprehensive report on the management survey and its implementation from the Board of Trustees prior to the next Annual Meeting."

The House recommended to the Board that "the office of Executive Vice President be filled, if possible, by a doctor of medicine who is an active member of the American Medical Association at the time of his appointment and who possesses the necessary managerial qualifications."

The House resolved that "the Executive Vice President prepare a report for the sessions of the House of Delegates as frequently as necessary but at least for each annual meeting and that the report be submitted in written form and referred to the appropriate Reference Committee" and that he be prepared "to present a brief oral summary of his report on request of the House."

Other resolutions adopted included these:

. . . That the Scientific Sections maintain responsible and responsive relations with all appropriate specialty societies.

. . . That the Board continue and expedite "its present activities to study and search for solutions to problems of medical professional liability."

. . . That the AMA, through its representatives on the JCAH, "take action to assure that accreditation be granted only to those institutions where the rights of the medical staff are not abrogated."

. . . That every county and state medical society initiate and maintain a "continuing program of active liaison between students at medical schools within their jurisdictions, preferably through active functioning chapters of SAMA."

. . . That the House go on record "favoring exploration of" establishing more uniform reciprocity arrangements among all states with respect to physican licensing.

. . . That the AMA adopt the following definitions and distribute them to all state medical associations for their individual consideration and guidance: " 'Usual' is defined as the 'usual' fee which is charged for a given service by an individual physician in his personal practice (*ie,* his own usual fee); 'Customary' is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socio-economic area; 'Reasonable' is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question."

The House also resolved that "whenever these terms are used in contracts or laws, that they be specifically defined in those documents."

Miscellaneous Actions or Reports

M. Louise C. Gloeckner, MD, delegate from Pennsylvania and the only woman in the House of Delegates, received a standing ovation and a bouquet of roses from the House at its opening session. She ended her service in the House with this meeting.

Aubrey Gates, executive assistant in the office of the executive vice president and former director of the Field Service Division, was extended "recognition and commendation" by the House in advance of his retirement in May, 1969.

A report on the Woman's Auxiliary was given to the House by Mrs. C. C. Long, president; one on AMPAC was presented by Blair J. Henningsgaard, MD, AMPAC president; and Alvin J. Ingram, MD, secretary of the Board of Trustees, reviewed the Association's Annual Report from the delegates' handbook.

Memorial resolutions were adopted for L. Howard Schriver, MD, Ohio, and W. Benson Harer, MD, Pennsylvania.

Remarks of the Former Executive Vice President

Following the adoption of three resolutions commending F. J. L. Blasingame, MD, for his services to the AMA as delegate, trustee and executive vice president, Dr. Blasingame addressed the House briefly at its opening session.

He called for a constitutional convention to re-evaluate the working of the AMA to equip it better for the "Herculean tasks" it faces, adding that the existing committee system is inadequate for the work. "This is a time for action, clarification and soul-searching for the AMA," he said, adding that the Association "can't afford to be concerned with internal bickering."

Dr. Blasingame said several questions should be asked by the AMA of itself, including these: How can the organization discharge its primary obligation as advocate of physician responsibility? Is the organizational structure adequate to meet the obligations of modern science? How can priorities be established to help both the physician and the patient? How can a dichotomy be avoided between the scientific and political aspects of medicine?

By a vote of the House, Dr. Blasingame's complete remarks will be published in the Proceedings of this Clinical Convention.

COMMITTEE ON EMOTIONAL HEALTH

Mr. President and Members of the House of Delegates:

The Committee on Emotional Health has discussed and approved the recommendation of the Subcommittee on Drug Abuse for a drug abuse treatment center which would act as a liaison office for physicians and addicts and as a treatment facility.

Effort has been made to urge the members of the Maryland Psychiatric Society to join the Medical and Chirurgical Faculty.

The committee also continued the study of the psychiatric treatment facilities available for children in the State of Maryland. As a result of this study, it was suggested that the Faculty support the Department of Mental Hygiene's request for more facilities and that it support Senate Bill 80 (1969) which allows for school boards to provide mental health services through the school systems.

Members of the committee met with Delegate Rosalie Abrams to discuss an emergency commitment bill for psychiatric patients.

The committee considered and made recommendations to the Postgraduate Education Committee concerning an addendum to be added to the Interpretation of Legal and Ethical Requirements for Hospital Staff Performance of Therapeutic Abortion.

The committee studied the Revised Mental Hygiene Laws and other legislation concerning mental health, which was introduced in the 1969 State Legislature, and appropriate action was taken.

The committee reaffirmed its position of encouraging general hospitals to develop services for psychiatric patients.

Respectfully submitted,

THURMAN MOTT, JR., MD, *Chairman*
JAMES CARSON, MD
IRVIN H. COHEN, MD
AUGUSTO J. ESQUIBEL, MD
IRENE L. HITCHMAN, MD
JOHN LERTORA, MD
RICHARD H. PEMBROKE, JR., MD
ERNEST E. HARMON, MD
ISADORE TUERK, MD
JOSEPH J. REIDY, MD
VIRGINIA HUFFER, MD
EXALL L. KIMBRO, JR., MD
ALBERT A. KURLAND, MD

SUBCOMMITTEE ON DRUG ABUSE: ALBERT A. KURLAND, MD, *Chairman,* WILLIAM E. ABRAMSON, MD, EMMETT P. DAVIS, MD, JAMES D. DRINKARD, MD, STEPHEN A. HIRSCH, MD, JULIAN W. REED, MD, ADDISON W. POPE, MD.

FINANCE COMMITTEE

Mr. President and Members of the House of Delegates:

The Finance Committee met with a representative of the T. Rowe Price Company and reviewed the investment portfolio of the special dedicated funds of the Faculty. Every security was reviewed individually.

In 1968, $63,000 of the Coggins Building Fund was placed under the counsel of T. Rowe Price. This addition, plus investment growth of 9.9% during the year, brought the total market value of the portfolio to $1,095,630 by December 31, 1968. The approximate income of the portfolio was $32,587. The yield on invested capital was 3.6%.

Due consideration was given to recommendations by T. Rowe Price to trade certain securities. A motion to follow the recommendations was unanimously passed, and T. Rowe Price was instructed to effect the necessary transactions.

The 1968 portfolio accomplishment was quite favorable when compared to all of the well-known financial indicators.

Respectfully Submitted,

KARL F. MECH, MD, *Chairman*
M. MCKENDREE BOYER, MD
E. W. DITTO, JR., MD
W. KENNETH MANSFIELD, MD
THEODORE OSIUS, MD

MED-CHI INSURANCE TRUST

Mr. President and Members of the House of Delegates:

The Med-Chi Insurance Trustees have met frequently during the year in their effort to continually improve the various programs administered by the Trust. The Trust now administers the following programs: (1) Accident & Sickness Disability Insurance (2) Major Medical Expense Insurance (3) Blue Cross and Blue Shield (4) Business Expense Disability (5) Life Insurance and (6) Keogh Retirement plan. Other types of programs are also under study, including a casualty package and automobile coverage.

The Accident & Sickness and Major Medical programs were liberalized in May 1968, as a result of good experience since their inception in 1965. Participation has increased significantly during the year. The Trustees are now working toward an even more liberal program for the members.

The Rates of our Blue Cross and Blue Shield group are lower than any other standard 30-day group program. Participation has increased substantially, and hopefully our rates will remain the best available.

The Life Insurance subscribers were recently sent a cash dividend of 9%. Beginning with July 1, 1969, the subscriber will have the option of taking a cash dividend or a higher dividend to be applied against the insurance premium. This program has also grown in participation.

The Med-Chi Members Retirement Plan has just completed its first year in operation. The results of its operation during the year are most gratifying. As of December 31, 1968, there were 322 participants in the plan. The equity fund had a market value of $579,864. The fund growth was 19.9% over the year period, which was over four times the accomplishment of the Dow Jones Average.

We feel that all of our programs are financially sound and the most economical available for the members of the Faculty. It is our hope the programs will continue to receive the enthusiastic support of the membership.

Respectfully submitted,

PAUL F. GUERIN, MD, *Chairman*
HARRY J. CONNOLLY, MD
PHILIP A. INSLEY, MD
WILLIAM J. MCCLAFFERTY, MD
ALFRED S. NORTON, MD
RICHARD A. YOUNG, MD

MARYLAND STATE MEDICAL JOURNAL

Mr. President and Members of the House of Delegates:

On May 13, 1968, a meeting of the Editorial Board was held. During this meeting the subject of a new format for the JOURNAL, specifically a new cover design, was discussed and many of the proposals were adopted and have been incorporated in the publication.

We are no longer suffering from a manuscript insufficiency due to the efforts of the staff, and the quality of the papers submitted for publication has been, on the whole, unusually high.

Richard L. Masland, MD, resigned from the Editorial Board and was replaced by Wilber R. Ellis, Jr., MD. At the end of December, the term of Houston S. Everett, MD, was completed and Edward S. Klohr, MD, was appointed to his position.

Because of the increasing scope of the JOURNAL, now in its 18th year of continuous publication, a new staff position was created for an editorial assistant.

During the year, the JOURNAL has received a number of favorable criticisms from the membership regarding its new look. It appears that we are reaching more of the membership than in previous years.

Respectfully submitted,

C. Thomas Flotte, MD, *Editor*
Judy Sowell, *Managing Editor*
Editorial Board:
Leon W. Berube, MD
Edward S. Klohr, MD
Ephraim T. Lisansky, MD
Wilber R. Ellis, MD
Edward C. H. Schmidt, MD
Moses Paulson, MD

LIBRARY AND HISTORY COMMITTEE
FINNEY FUND COMMITTEE

Mr. President and Members of the House of Delegates:

During the calendar year the library has continued to increase its acquisitions in books particularly, while weeding out and discarding obsolete titles under the supervision of Mr. Lee Ash, library consultant. This program will account for a decrease in number of books now held by the library, since the number of volumes withdrawn from the collection exceeds the number of new volumes added. However, this readjustment indicates a definite revitalization of the book collection, eventually leading to a more viable library of current publications, while retaining the valuable collection of our rare books, history of medicine, manuscripts and incunabula.

The staff status remained approximately the same as in 1967, with the addition of one professional part-time librarian, Miss Sarah Katzoff, who had previously worked only during summers.

During the year, Mrs. Sanford, librarian, attended the national meetings of the Special Libraries Association in Los Angeles, the Medical Library Association, Denver, Colorado, regional meetings of the Middle Atlantic Medical Library Association in October, and the D.C.-Delaware-Maryland Hospital Association, Washington, in December.

At the Hospital Association meeting she participated in a panel discussion titled *"How* to get *what* you want *when* you want it." Other speakers represented the National Library of Medicine, the Medical College of Virginia at Richmond and the Baltimore Hospital Librarians' Association, sponsor of the meeting. This was the first program for medical and hospital librarians at the annual Tri-State Hospital Association meeting and probably will be continued since it was well attended and the group seemed enthusiastic.

Very little equipment was added during the year, the total being one new typewriter, a two-drawer file cabinet for periodicals acquisitions, and a small reference table for use at the abstracts and index shelves. No large items of furniture were purchased, pending removal of the large table from the reading room.

The exhibits and collections of books for the annual meetings were manned, as usual, by a professional librarian or Library Committee member at all times. Also, again the library cooperated with the committee on sports medicine by preparing a new updated bibliography on the subject for their Seminar on Sports Medicine held at Catonsville Community College in August.

Several meetings were attended by the librarian to discuss the status of the Middle Atlantic Regional Medical Library. The first was an all day session held at the National Library of Medicine with librarians from Welch Medical Library; Health Sciences Library at the University of Maryland; The Medical College of Virginia School of Medicine, Richmond; University of Virginia Medical School at Charlottesville; University of West Virginia School of Medicine; Georgetown University Medical School; George Washington University School of Medicine, and staff members from the National Library of Medicine. This was followed by another session after all participants had prepared working papers outlining their possible contributions to the motivation of an effective regional medical library in this area. The consensus of the second group was that nearly all libraries concerned would be able to increase their services only with additional personnel and funds for enlarged operation. The three major medical libraries already carry a considerable portion of the interlibrary loan and reference service in Baltimore and the surrounding areas. The National Library of Medicine services, on a rush basis, requests for items not available locally as a special accommodation in lieu of an official regional medical library such as most of the other regions now have.

Mr. Lee Ash has continued his consultation services during the year, finding many valuable items in need of repair, binding, or just plain salvaging. He will probably need most of next year to finish his survey; then the rare books and history of medicine libraries can be organized in one area—and hopefully in a more suitable environment than is now available. At present, a grill has been installed on the fourth stack so that this collection can be more securely housed.

Respectfully submitted,

Library and History Committee
Paul F. Guerin, MD, *Chairman*
Louis Krause, MD
H. Baldwin Streett, DDS
Robert B. Goldstein, MD
Thomas C. Hill, MD
Katharine A. Chapman, MD

Finney Fund Committee
D. C. W. Finney, MD, *Chairman*
Richard W. TeLinde, MD
Richard V. Hauver, MD
John P. Haberlin, MD
Richard G. Coblentz, MD

LIBRARY STATISTICS—1968

Circulation	
Books	3,135
Journals	4,954
Pamphlets (VF)	300
Total	8,807
Interlibrary Loans requested	110
Interlibrary Loans requested from Med-Chi (Note: This does not include requests charged directly over circulation desk, only formal interlibrary loan requests)	308
Attendance	2,012
Courtesy cards issued	12
Pages Xeroxed	8,556
Bibliographies	196
Reference requests by telephone	3,355
Acquisitions	
Books	1,003
Bound journals	510
Total	1,513
Gifts	
Books	350
Journals	4,536
Total	4,886
Books withdrawn	1,397
Total volumes in collection	93,077

MEDICAL ANNALS OF MARYLAND COMMITTEE

There have been no changes in the activities of this group since the report submitted at the 1968 Annual Meeting.

Respectfully submitted,
LESLIE E. DAUGHERTY, MD

MEDICAL EMERGENCY DISASTER SERVICE COMMITTEE

Mr. President and Members of the House of Delegates:

No meetings of this committee were held during this year. Therefore, no action was taken by the committee.

Respectfully submitted,
JOHN W. ASHWORTH, MD, *Chairman*
EDMUND G. BEACHAM, MD
GINA M. GLICK, MD
LAURISTON L. KEOWN, MD
EDWARD L. J. KRIEG, MD
KIRK MOORE, MD
WILLIAM J. PEEPLES, MD
KENNETH PHILBROOK, MD
EUGENE J. RILEY, MD
CHARLES J. SAVARESE, MD
E. RODERICK SHIPLEY, MD
ROBERT J. WILDER, MD
R. LANE WROTH, MD

MARYLAND MEDICAL SERVICE, INC. BOARD OF TRUSTEES

Mr. President and Members of the House of Delegates:

Again in 1968, the Maryland Blue Shield Plan recorded significant progress in all phases of its operations—enrollment, claims processing, general administration, and physician participation.

Membership in the underwritten programs increased by 106,457 (10.7%), bringing total enrollment to 1,097,045 at the end of the year. According to the latest figures available from the National Association of Blue Shield Plans (for the nine months ended September 30, 1968) the percentage of gain, well above the national average of 1.95%, was one of the highest in the country. The Maryland Plan is now the 16th largest among the 82 Plans in the United States, Puerto Rico, and Canada. At year's end our membership was 86.5% of that of our companion Blue Cross Plan, as compared with 82.5% a year ago.

The Plan intensified its efforts to convert as many subscribers as possible from the low fee schedule Plan A to either Plan B or the usual and customary fee program, Plan C. The success of the campaign is revealed by the year-end tabulation which shows that only 10.8% of total enrollment was in Plan A, as compared with the 17.6% of December 31, 1967.

Plan C enrollment increased substantially during the year. Including over 118,000 high-option Federal employees, effective January 1, 1969, total Plan C membership is well over 240,000, double the 120,000 of one year ago. Expressed in percentage of total enrollment, persons covered under usual and customary fee based contracts accounted for more than 22% of total membership.

Incurred claims during 1968 amounted to $20,553,000, an increase of about $2,354,000 over 1967. An average of 11,600 claims per week were processed during the year from our underwritten business, well above the 8,600 of a year ago. Medicare B claims payments amounted to $10,865,000, up by more than $1,898,000 from the previous year; the bill processing volume under this program was about 8,600 per week throughout the year. Another $677,528 was paid to Maryland physicians under CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) last year.

The members of our Professional Relations Department made 3,686 visits to professional offices during 1968, helping materially to maintain the Plan's liaison with physicians and their office assistants. In addition, our representatives attended 18 meetings of county medical societies, specialty organizations, office assistants' associations, and medical secretarial student classes. At the end of the year 3,765 physicians were in participating status, representing 91% of those physicians currently submitting claims to the Plan.

Blue Shield also renegotiated its operating agreement with Blue Cross with the result that all personnel in those departments, engaged solely in Blue Shield work, were transferred to Blue Shield employee status on January 1, 1969.

Maryland Blue Shield lost two Trustees by death during the year—F. Ford Loker, MD, and C. Parke Scarborough, MD. Both gentlemen served Blue Shield well and faithfully; their passing is recorded with deepest regret.

The Board of Trustees joins me in expressing appreciation to the Plan's administrative staff for its many

contributions to the successful conduct of the Plan's business during the year.

Respectfully submitted,
J. Sheldon Eastland, MD

MEMBERSHIP COMMITTEE

Mr. President and Members of the House of Delegates:

There was no Membership Committee appointed and no meetings held this year.

Respectfully submitted,
William G. Helfrich, MD, *Chairman*

POLICY AND PLANNING COMMITTEE

Mr. President and Members of the House of Delegates:

An Ad Hoc Committee on Utilization Review in Nursing Homes and Extended Care Facilities was appointed by the Policy and Planning Committee. Invited guests and consultants attended a meeting of the committee.

The attention of the House of Delegates is called to the urgency of encouraging the formation of Utilization Review Programs throughout the state because of the wide variation in the quality of medical care in various nursing facilities. The experience of the Montgomery County Medical Society in coordinating utilization review of Extended Care Facilities in that county has proved the feasibility of such a program.

First, definitions of the three types of nursing homes must be clarified:

Nursing Home—Extended Care means any institution which renders skilled nursing care to persons suffering from disease or other disabilities. (Skilled nursing care includes care rendered by registered professional nurse or licensed practical nurse under the supervision of a registered nurse.)

Nursing Home—Long Term Care means rendering nursing care (by or under supervision of an RN or an LPN) to persons suffering from disease or other disabilities.

Personal Care Home means any institution which renders personal care (services which an individual would normally perform for himself but for which he is personally dependent on others because of advanced age, infirmity, physical or mental limitations).

After serious and searching discussion the following proposals are recommended for adoption as policy of the Medical and Chirurgical Faculty of the State of Maryland:

1. The function of utilization review in Extended Care Facilities should be administered on the local county or regional (group of adjacent counties) level. The Medical and Chirurgical Faculty's role should be one of information and guidance.
2. A committee of the Faculty (already existing or newly appointed if necessary) should be charged with gathering information concerning utilization review from all available sources and stimulating formation of local or regional review committees. This information, along with administrative suggestions should be available to any component society or group of societies requesting such.
3. It is recommended that the Medical and Chirurgical Faculty endorse, as Faculty policy, the principle of utilization review in all Nursing Home Facilities in addition to that required under State and Federal regulations as a means of assuring quality medical care for the patients in such nursing homes.

Arthur T. Keefe, MD, *Chairman*

MARYLAND MEDICAL POLITICAL ACTION COMMITTEE

Mr. President and Members of the House of Delegates:

Since Dr. Joe Hooper reported to you at this time last year on the Maryland Medical Political Action Committee, we have elected another congressman in Maryland. In last year's report, we stressed our determination to add a new face in congress. The contest was a close one but we won. As you know, this was Larry Hogan's victory in the Fifth Congressional District, which made our delegation in the House of Representatives four and four—a truly bipartisan representation in the State of Maryland. A total view of November '68 would show that we held our previous gains and added one to the score.

At the same time, for the first time, we got into a Senate race and found the experience very pleasing. Senator "Mac" Matthias was very cognizant of our help, and in him, we have a very sympathetic ear.

Now one of our best representatives has become chairman of his national party and, hence, our work next year will be vitally needed. We must find and elect his replacement; and so it becomes evident that our work seems never to be done. Finding new candidates and electing them while holding previous gains will go on year in and year out. Also, when we become active on the local scene as we would very much like to do, our work load will be increased considerably. The elections of 1968 are behind us and 1970 looms just around the corner.

You may be amazed to know that the American Medical Political Action Committee, which is our parent organization with headquarters in Chicago, ranks third in the nation's political action groups. We are just behind the national parties and COPE, which is labor's action arm. We would like to thank you for your political awareness in the past and ask you to sharpen it up as much as possible in the future. And I would like to close with a personal word. We have realized our goals in the past. We have set modest goals. These are to increase our membership to over 300 people and we are well over that now. We are here to stay. Secondly, we want and can now practice effective and coordinated candidate support. The candidates know who we are and want our support. And finally, we want to stimulate and educate ourselves and our members in politics and in this regard the newsletter, which last year was written by Mrs. Karl Mech, was a very great help indeed.

I would like, while still serving with this group, to see the leaders of state medicine, the members of the House of Delegates become members of this group. And I ask your support, and anyone who is interested in becoming active on the Board of Directors, we certainly

would like to hear from you because we need new faces and new help.

Respectfully submitted,
JOSEPH H. HOOPER, JR., MD, *Chairman*

COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE, AND PUBLIC HEALTH

Mr. President and Members of the House of Delegates:

This active Committee, through its many subcommittees, participated in numerous educational projects. During the 1968-69 year, eleven subcommittees and several ad hoc committees were appointed. To promote better liaison, representatives from the Regional Medical Program and from the Faculty's Emotional Health Committee were appointed to serve on this standing committee.

A new Subcommittee on Joint Anesthesia Study, which at this writing has not yet held any meetings, has been appointed upon Council recommendation. For many years there has been a Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department, and now there is to be a similar committee on a State level, which will either encompass or will coordinate with the City committee. The City committee has acted as such a valuable teaching program that a state-wide study is certain to prove worthwhile.

William L. Stewart, MD, who was the Faculty's representative at the First National Conference on Continuing Medical Education sponsored by the AMA, gave a report at one of the committee meetings. This was obviously a most informative conference on the various areas of postgraduate education with many salient recommendations for state medical societies.

A symposium on "The 20th Century Adolescent" was held in November 1968 under the guidance of a special subcommittee, and arranged and supported financially by Geigy Pharmaceuticals. It is believed this was the most successful function of this type the Faculty has ever sponsored with an attendance at the afternoon session of over 1,300 and over 900 at the banquet. Many people were turned away because of the space limitations of the meeting facilities. In view of the outstanding success, Geigy Pharmaceuticals has made a tentative offer to sponsor another symposium in 1970.

Tentative plans are being considered for a symposium on infectious diseases to be held in the fall of 1969. This would be in conjunction with the National Communicable Disease Center.

It was agreed that whenever Council approval was desired in connection with a recommendation from a subcommittee, upon approval of this parent committee, the chairman of said subcommittee was to request permission to be present at the Council (or Executive Committee) meeting to discuss the matter involved and answer questions.

Subcommittee on Airport Medicine:

The chairman of this subcommittee personally conducted an investigation regarding the medical facilities at Friendship Airport. The managers of the four largest airlines, who he contacted, all agreed that the lack of physicians in the airport is of concern to them in terms of incoming passengers and accidents to their own employees. Various means of handling the situation were discussed, but nothing can be considered until the new State Airport Authority has been established. A resolution, which was passed by this committee regarding adequate medical coverage at Friendship Airport, received Council approval, and the chairman of the State Airport Authority was notified. The subcommittee is continuing to direct its efforts toward this problem as well as to consider what can be done about medical coverage for the many small airports throughout the State.

Subcommittee on Alcoholism:

This subcommittee was instrumental in having the Alcoholism Control Bill passed at the 1968 session of the State Legislature. However, the companion bill, which would have provided funds for implementing the bill was not passed. This incongruous action refuted the usefulness of the bill passed, but efforts are currently being made to correct this.

The subcommittee obtained Faculty approval for sponsorship of a seminar on "The Physiological Aspects of Alcoholism." This was held at the Belvedere Hotel in May and, while the attendance was considerably less than anticipated, it was most enthusiastically received by those who were present. Four hundred copies of the Manual on Alcoholism were distributed to Faculty members at the 1968 Annual Meeting. A local judge, who is concerned about the problem of alcoholism, has been invited to join the subcommittee as a consultant.

Members of the subcommittee participated in a seminar held at College Park to train personnel to work with alcoholics. They also participated in a conference, cosponsored by the Faculty, to discuss implications for general hospitals of the "Comprehensive Intoxification and Alcoholism Act." Another conference which this subcommittee sponsored was on the "Treatment of Acute Phases of Alcoholism Including Delirium Tremens."

Two motions have been passed and submitted for Executive Committee approval to the effect that the Faculty endorse the 1970 fiscal year budget of the Department of Mental Hygiene to support the alcoholism program through the Community Mental Health Program; and that the Faculty support legislation providing for State financing of Community Health Programs, including alcoholism.

Subcommittee on Cancer:

The Faculty Council adopted the recommendation of this subcommittee that a study be made regarding a central cancer registry provided it were on a voluntary basis. The Subcommittee felt that a registry on a voluntary basis would not be workable. The Council disapproved the recommendation, because of lack of information, that the Faculty sponsor cancer detection workshops.

Child Welfare Subcommittee:

A school examination form which originated within this subcommittee and the State Mental Health Department, after careful study and minor revisions, received Council approval. It has now been approved by the State Board of Education and will be put into use at the school term beginning in the fall of 1969.

The recommendations of an Ad Hoc Committee on PKU Legislation was adopted by the Council. The statement regarding the distribution of mumps virus vaccine, as recommended by the American Academy of Pediatrics, was endorsed by the Faculty. The subcommittee is in accord with a bill that has been introduced in the State Legislature regarding required immunizations before admission to school, but does not feel that specific immunizations should be spelled out in a law.

Council approval was received for evaluation to be made of a hearing and vision screening program for three- to five-year-old children in Maryland. An Ad Hoc Committee has been appointed for this purpose.

Ad Hoc Committee on Hearing and Vision Screening:

Serving on this committee, in addition to pediatricians and an otolaryngologist, are several audiologists, and the Executive Director of the Maryland Society for the Prevention of Blindness. This study is being made, upon Council recommendation, following the publicity received about a program in Minnesota, as many requests for information about such a program have been received in the Faculty office. There is no problem involved with the vision screening as this can be carried out by the Maryland Society for the Prevention of Blindness. However, there are many factors to be evaluated in connection with the hearing screening. The program would involve well-trained volunteers. A detailed, thorough study is in progress at present, and it is hoped by September 1969, specific recommendations can be made. It is definitely felt that this will be a most worthy project and an extremely good public relations activity for the medical profession.

Subcommittee on Chronic Respiratory Diseases:

Of prime consideration to this subcommittee has been the situation regarding beds for tuberculosis patients in Maryland. It is a recognized fact that, while the number of tuberculosis patients is on the decrease, Baltimore has one of the highest rates in the country. The current problem has arisen out of the reduction of the number of beds at the Baltimore City Hospitals from 150 to 90, and more patients being referred to Mt. Wilson, which is solely a TB hospital. The latter is a State-supported hospital while the former receives reimbursement in the same amount as the cost for patients at Mt. Wilson. However, the cost of maintaining a patient in the City Hospitals is higher and the difference must come from City funds, which are being curtailed. Patients at Mt. Wilson, who have medical and/or surgical conditions in addition to TB, must be treated at another facility, which is not the case at City Hospitals. Decision is pending as to whether TB patients are to be handled at only one hospital and, if so, which of the two aforementioned will be selected. The State has requested budget funds to establish TB units in certain general hosptials since eventually there may not be sufficient patients to warrant special hospitals.

A motion was referred to Council to the effect that this is a problem of concern to the Medical and Chirurgical Faculty, and that the Faculty go on record as approving the continuation of the care of TB patients at Baltimore City Hospitals. Council, after careful consideration, adopted a motion that the President of the Faculty appoint an ad hoc committee to consider this matter. At this writing no further report has been made available.

A seminar is being planned on respiratory diseases, of which the Faculty is to be one of the co-sponsors with the USPHS supporting it financially. The Chairman of this subcommittee is chairman of the planning committee for the seminar.

Subcommittee on Diabetes:

Council approval was received on a motion that the Faculty endorse the principle of an annual Diabetes Detection Drive, with the understanding that local component societies be free to implement this at their pleasure. A letter was sent to each component society asking it to organize a Drive on a local basis. The Drive in November 1968 was most successful in Baltimore city, but no record is available as to how much was done in each county.

The chairman has requested each component society to appoint someone to serve on this subcommittee to work with health department officers in arranging future Diabetes Detection Drives. The Chairman also recommended that each year the President of the Maryland Diabetes Association also be chairman of the Faculty's subcommittee. No action has been taken on this.

Subcommittee on Maternal Welfare:

The Council adopted the Guidelines for Hospital Medical Staffs for the Performance of Therapeutic Abortion, which were set up by an ad hoc committee after the Law was passed at the 1968 session of the State Legislature. The Law went into effect in July 1968 and a copy of the Guidelines was sent to every member of the Faculty and to every hospital in the State. The State Board of Health and Mental Hygiene, upon the recommendation of the Faculty, appointed this subcommittee as an advisory committee on this subject to the Board. In view of this, a psychiatrist was appointed to serve on the subcommittee. A request was also forwarded to the State Board, and approved, that it work with the Faculty on the development of a reporting form for all therapeutic abortions. This form was prepared and distributed to all hospitals in the State.

A motion was submitted by this subcommittee to the parent committee that "Continuation of a pregnancy in a 15-year-old or under may represent a grave impairment to the mental health of the mother and, therefore, warrants a psychiatric evaluation." This evolved from the concern of the Baltimore City Health Department about pregnancies in the younger teen-agers who might require a therapeutic abortion. The motion was referred to the Faculty's Emotional Health Committee for an opinion. That committee submitted an amended version of the motion and this has now been sent to the Council of the Faculty for approval. The amendment was in the last part of the motion, which now reads ". . . warrants an evaluation for the possibility of a therapeutic abortion."

An Ad Hoc Committee on Perinatal Mortality has been appointed and is most active. It is composed of members of this subcommittee and members of the Subcommittee on Child Welfare. A questionnaire of vital statistics on perinatal deaths is now in the process of being prepared. A scientific exhibit will be displayed by this Ad Hoc Committee at the Annual Meeting of the Faculty in April. This exhibit will contain the minimum resuscitation equipment necessary in a delivery room, information on the Apgar procedure, etc., and is being supported by funds from outside sources.

This subcommittee continues to review all maternal deaths in the State. The causes of death, by diagnosis, in these obstetric patients are reported. The 1967 report was completed too late for inclusion in the 1968 annual report and is as follows:

Table 1

CAUSES OF MATERNAL MORTALITY

	White	Nonwhite	Total
Infection			4
Postabortal		3	
Puerperal			
Peritonitis	1		
Other			5
Cerebral Hemorrhage	2	2	
Unknown	1		
Hemorrhage			3
Ruptured Ectopic		2	
Post Partum			
Ruptured Uterus		1	
Embolism			2
Pulmonary	2		
Amniotic Fluid			
Toxemia			0
Eclampsia			
Unclassified			
Total			14

Table two shows the maternal deaths occurring in Baltimore and the counties:

Table 2

MATERNAL DEATHS ACCORDING TO RACE & SUBDIVISION

	Baltimore	Counties	Total
White	1	4	5
Nonwhite	7	2	9
Total	8	6	14

It is interesting to note that in Baltimore five of the deaths occurred in nonviable pregnancies. Three were infected abortions and two were ruptured ectopic pregnancies. In the counties, all maternal deaths occurred in viable pregnancies. Out of the six deaths in the counties three were voted preventable and no determination could be made regarding a fourth since the patient died unattended and no autopsy was obtained.

Of the city deaths, three were due to infected criminal abortions and obviously preventable. In all, six of the fourteen deaths were voted preventable, and of these, in all but one case, the preventability was believed the responsibility of the patient. It would therefore appear that through health information and education we might possibly reduce this maternal mortality by nearly 50%.

It is of further interest to note that there were no maternal deaths from toxemias, usually one of the three leading causes.

Subcommittee on Continuing Medical Education (MEDIC):

The MEDIC network continues in operation with a complement of thirty-eight community hospitals, plus outlets at the Hospital Council of Maryland, State Department of Health, the Medical and Chirurgical Faculty and the Baltimore County Health Department. In addition, equipment has been installed at the Headquarters for Civil Defense in the State of Maryland. The purpose is to allow the network to be used for interhospital communication in the event of a civil emergency. The network was put to such a use during the riots of Baltimore city, April 1968.

The expenses for the MEDIC network have remained constant but the cost to the Medical and Chirurgical Faculty has been reduced by 50% due to a grant supplied by the Merck, Sharp and Dohme Pharmaceutical Company. A similar grant has been promised for the coming year.

Approval by the House of Delegates is requested on the following recommendation:

> **That the MEDIC Network be continued and that sufficient funds be appropriated to the extent needed to finance the operations for the coming MEDIC year.**

Programs offered over the MEDIC network have included a weekly medical lecture which is rebroadcast on three separate occasions during the following week, medical rounds presented weekly from the University of Maryland Hospital, and both medical and pediatric rounds presented weekly from The Johns Hopkins Hospital. A program of CPC's is offered on a weekly basis originating from The Johns Hopkins Hospital. Use has been made of the MEDIC network for program presentation by the School Health Committee of the Maryland Chapter of the American Academy of Pediatrics, the Committee of Joint Anesthesia Study of the Baltimore City Medical Society and City Health Department, the Baltimore City Medical Society, and the State Health Department. Committees of the Faculty have also used this facility for meetings and announcements.

For the next year modifications in program planning will be made based on the experience of the past and projected needs for the future.

Subcommittee on the Medical Aspects of Sports:

Approval of Council was received for a physical examination form and guidelines for medical evaluation of candidates for school sports activities. At present, these forms are in the hands of the Board of Education awaiting approval and implementation. A reporting form for sports injuries is also being considered within the subcommittee. This will make possible a study of the epidemiology of sports as to what injuries occur in connection with specific sports and in what schools they occur most frequently.

The second annual seminar on the Medical Aspects of

Sports was held at the Catonsville Community College in August 1968. There were 189 in attendance and only $68.28 of the $200 allotted by the Faculty was spent. The third annual seminar is scheduled for December 1969 for which the Faculty has agreed to allot up to $300, contingent on the subcommittee giving consideration to the sale of exhibit space—the income from which would help underwrite the cost of the program. It is planned to sell exhibit space, as there were many interested companies in 1968.

Speakers' Bureau Subcommittee:

This subcommittee, which will provide speakers for medical and paramedical groups, has not received any requests this year, even though the availability of speakers has been publicized within the Society.

Subcommittee on Traffic Safety:

A most successful seminar was held in May 1968 with leaders of various professional and lay organizations. As a result of this seminar, an organization has been formed which is known as the United Organization for Traffic Safety. This is to be a continuing organization that each year will concentrate on one or two traffic safety bills. One of the bills on which effort is being focused at the 1969 session of the State Legislature is "Implied Consent." Maryland is apparently behind other states as far as this law is concerned—17 states already have such a law in effect. The only other area in which Maryland is behind is in a reportable disease law, but the Department of Motor Vehicles is planning to include on the driver's license renewal application that the driver is responsible for reporting any diseases or physical disabilities he may have. In other areas of traffic safety legislation Maryland is ahead of most states.

The Visual Acuity Bill, which the Faculty supported in 1968, was passed by the State Legislature at that time.

This subcommittee now has a monthly page in the Maryland State Medical Journal devoted to various aspects of traffic safety. One issue of the Journal has had a traffic safety related cover, which was submitted by this subcommittee. The October 1969 issue will be dedicated to the medical aspects of traffic safety.

From this report it is obvious that the committee and its many subcommittees have been engaged in numerous worthwhile projects valuable to both the profession and the public.

I am most happy and appreciative of the privilege of having served as chairman for the past two years. My sincere thanks go to each member of the committee and each subcommittee member for the time and effort expended in the interest of postgraduate education, preventive medicine, and public health.

Respectfully submitted,

John Whitridge, Jr., MD, *Chairman*
Ruth W. Baldwin, MD
Robert G. Chambers, MD
H. Garland Chissell, MD
Irvin H. Cohen, MD
John B. De Hoff, MD
DeWitt E. DeLawter, MD
Robert E. Farber, MD
Marion Friedman, MD
Karl M. Green, MD
John R. Davis, MD
Frederick J. Heldrich, Jr., MD
John H. Hirschfeld, MD
Norman B. Hollingsworth, MD
D. Frank Kaltreider, MD
Milton B. Kress, MD
Julius Loebl, MD
William J. Peeples, MD
Joseph B. Workman, MD
Bruce E. Strem, PhD, *Advisory Member*

SUBCOMMITTEE ON AIRPORT MEDICINE: Julius Loebl, MD, *Chairman,* Aris T. Allen, MD, Donald Barrick, MD, John B. De Hoff, MD, James E. Toher, MD.

SUBCOMMITTEE ON ALCOHOLISM: John R. Davis, MD, *Chairman,* Conrad Acton, MD, Edmund G. Beacham, MD, John H. Hirschfeld, MD, Irene L. Hitchman, MD, Isadore Kaplan, MD, Harry F. Klinefelter, MD, Kenneth Krulevitz, MD, Abraham M. Schneidmuhl, MD, Maxwell N. Weisman, MD.

SUBCOMMITTEE ON CANCER: Robert G. Chambers, MD, *Chairman,* Cyrus L. Blanchard, MD, Fernando G. Bloedorn, MD, Elizabeth G. Brings, MD, Earl C. Clay, Jr., MD, John B. De Hoff, MD, Louis E. Goodman, MD, Samuel Lumpkin, MD, Howard W. Jones, Jr., MD, Conrad G. Julian, MD, George A. Maxwell, MD, Alan C. Woods, Jr., MD.

CHILD WELFARE SUBCOMMITTEE: Karl M. Green, MD, *Chairman,* John A. Grant, MD, Murray M. Kappelman, MD, Lawrence C. Pakula, MD, Robert E. Yim, MD, Benjamin D. White, MD, Charles E. Wright, MD, Joseph J. McDonald, MD, R. M. N. Crosby, MD, Richard C. Lang, MD, Margaret L. Sherrard, MD.

AD HOC COMMITTEE ON HEARING AND VISION SCREENING of the Subcommittee on Child Welfare: Karl M. Green, MD, *Chairman,* Cyrus L. Blanchard, MD, John A. Grant, MD, Murray M. Kappelman, MD, Margaret L. Sherrard, MD.

SUBCOMMITTEE ON CHRONIC RESPIRATORY DISEASES: Milton B. Kress, MD, *Chairman,* Warde B. Allan, MD, Edmund G. Beacham, MD, Otto C. Brantigan, MD, Robert E. Farber, MD, A. Murray Fisher, MD, John H. Hirschfeld, MD, Meyer W. Jacobson, MD, Elliott Michelson, MD, John E. Miller, MD, William J. Peeples, MD.

SUBCOMMITTEE ON DIABETES: DeWitt E. DeLawter, MD, *Chairman,* Henry V. Chase, MD, Gerard Church, MD, John R. Davis, MD, John B. De Hoff, MD, Seth H. Hurdle, MD, William H. Patrick, MD, Thaddeus E. Prout, MD, Julian W. Reed, MD, Charles E. Shaw, MD, Abraham A. Silver, MD, John C. Stauffer, MD, Samuel J. N. Sugar, MD, Donald O. Wood, MD.

MATERNAL WELFARE SUBCOMMITTEE: D. Frank Kaltreider, MD, *Chairman,* J. Tyler Baker, MD, George H. Davis, MD, Rafael Garcia-Bunuel, MD, John S. Haught, MD, Mervyn L. Carey, MD, Hugh B. McNally, MD, J. King B. E. Seegar, MD, Jonas R. Rappeport, MD, Edwin R. Ruzicka, MD, Herbert L. Yousem, MD.

AD HOC COMMITTEE ON PERINATAL MORTALITY of the Maternal Welfare Subcommittee: J. King B. E. Seegar, MD, *Chairman,* George H. Davis, MD, Rafael Garcia-Bunuel, MD, Richard C. Lang, MD, Joseph J. McDonald, MD, Edwin R. Ruzicka, MD.

MEDIC SUBCOMMITTEE: Frederick J. Heldrich, Jr., MD, *Chairman,* Robert Biern, MD, Edmund G. Beacham, MD, Daniel Bakal, MD, J. Emmett Queen, MD, George J. Weems, MD, George M. Simons, MD, Albert Naham, MD, R. Lane Wroth, MD, Carl J. Houmann, MD, Thomas Crawford, MD, Robert J. Furie, MD, Thaddeus E. Prout, MD, Peter Rodman, MD, Samuel P. Asper, MD, Arthur T. Keefe, Jr., MD, Aubrey Richardson, MD, Irving Freeman, MD, Edward Cotter, MD, Harry Beck, MD, Richard A. Yates, MD, William Schuman, MD, William Morgan, MD, Frederick Johnson, MD, Edwin J. Jensen, MD, James D. Carr, MD, Albert P. Marsh, MD, Leon Sheer, MD, John Tuohy, MD, Robert E. May, MD, William C. Mulford, MD, Pietro U. Capurro, MD, Wilson Grubb, MD, Donald Roop, MD, Charles Spencer, MD, David Marine, MD.

SUBCOMMITTEE ON THE MEDICAL ASPECTS OF SPORTS: John B. De Hoff, MD, *Chairman,* James W. Banks, MD, Robert G. Brewer, MD, Alvin Brown, MD, William C. Duffy, MD, Charles M. Henderson, MD, G. Overton Himmelwright, MD, John M. Krager, MD, Edmond J. McDonnell, MD, Andrew C. Mitchell, MD, Ross Z. Pierpont, MD, Marcus Stephanides, MD, Ramsay B. Thomas, MD, Leonard Wallenstein, MD.

SPEAKERS BUREAU SUBCOMMITTEE: Joseph B. Workman, MD, *Chairman.*

SYMPOSIUM SUBCOMMITTEE: John Whitridge, Jr., MD, *Chairman,* John B. De Hoff, MD, Frederick J. Heldrich, Jr., MD, John H. Hirschfeld, MD.

TRAFFIC SAFETY SUBCOMMITTEE: Ruth Workman Baldwin, MD, *Chairman,* Timothy D. Baker, MD, Solomon E. Barr, MD, Rudiger Breitenecker, MD, George Cohen, MD, John E. Gessner, MD, Irene L. Hitchman, MD, Paul V. Joliet, MD, Howard F. Kinnamon, MD, Robert R. R. Roberts, MD, Perry Stearns, MD, Robert J. Wilder, MD.

COMMITTEE ON PROGRAM AND ARRANGEMENTS

Mr. President and Members of the House of Delegates:

In 1968 another successful Annual Meeting of the Medical and Chirurgical Faculty was held at the Alcazar, April 17, 18, 19. This was the 170th Annual Meeting of the Faculty, and was arranged under the chairmanship of Thaddeus E. Prout, MD. The registration, 1,310, was just slightly lower than the previous year which was an all-time high. It was felt the Caribbean Cruise Convention immediately following the sessions at the Alcazar may have curtailed attendance by some physicians. The scientific program was very well received, and the report of the Medical Exhibitors Association was excellent from the exhibitors' viewpoint. The Health Evaluation Tests were again given with 453 persons taking the tests. Many physicians and their families participated in the Caribbean Cruise Convention. There were two scientific sessions, plus medical films shown daily aboard ship. These were attended by practically every physician on the cruise.

The site of the 1968 Semiannual Meeting was again the Diplomat Motor Hotel in Ocean City, Maryland. This was held September 5, 6, 7, with the highest registration (581) of any Semiannual Meeting of the Faculty. The several specialty societies which held scientific programs in conjunction with the Faculty's meeting had splendid attendance. Both the banquet, at which Roy O. Scholz, MD, spoke on "Medico's First Decade," and the crab feast luncheon were well attended with a maximum number of reservations received. However, there were many complaints regarding the facilities of the Diplomat and the cooperating motels. A decision has now been made, with Council approval, to hold the 1969 Semiannual Meeting at the Hotel Hershey, in Hershey, Pennsylvania. The facilities there will be quite adequate with many meeting rooms and many forms of entertainment for both the physicians and their wives.

The plans for the 1969 Annual Meeting are complete at this time with a varied program of interest to all physicians. The grand rounds which proved quite popular in 1968 have again been scheduled, with the University of Maryland School of Medicine presenting medical grand rounds and The Johns Hopkins University School of Medicine presenting surgical grand rounds. One session will be devoted to a coronary care panel, another to diagnostic and treatment procedures applicable for general practice. There will also be several endowed lectureships presented by prominent physicians.

The Dean of The Johns Hopkins University School of Medicine sometime ago sent an invitation to the Faculty to hold all or part of the 1969 Annual Meeting in the school's new facilities in conjunction with its 75th anniversary. In the summer of 1968 an inspection of the new buildings was made and, in addition to not being assured the buildings would be completed, it was found there would not be sufficient space available for the number of exhibits usually displayed at the Annual Meeting. However, on Saturday, April 12, the members of the Faculty have been invited to attend medical and pediatric grand rounds in the new Turner Auditorium, to be followed by a tour of the many new treatment and research centers at Hopkins. It is hoped many of our members will take advantage of this opportunity.

The change in the format of the annual luncheon in 1968 did not prove as successful as anticipated. The type of Round Table Luncheon, which has been held for many years has been planned again for this year, but with a fewer number of tables. This reduction in the number of tables has been made in order to have better attendance at the ones planned and to avoid sound interference between tables by having them placed farther apart. The annual Presidential Reception and Banquet will be held with the Chairman of the Board of Trustees of the American Medical Association giving a short talk, which will be followed by dancing. An innovation at this Annual Meeting will be a Hospitality Night on Wednesday evening to which all members of the Faculty and their wives are invited, as well as the representa-

tives of exhibiting companies. This will replace the usual cocktail party given for the exhibitors.

Once again the Health Evaluation Tests, which have proven most worthwhile and have brought to light several previously unknown abnormal conditions among the physicians, will be held. As of this writing, there are not quite the usual number of technical exhibit booths reserved but, according to a study which has been made by the Pharmaceutical Manufacturers Association, this is the trend throughout the country. In comparison, our Society has suffered less of a reduction than other state societies and it is felt the income from the exhibits will be only slightly below that of 1968. Scientific exhibits by members of the Faculty and physicians from nearby states have been accepted to the full capacity of the exhibit hall.

Our committee takes this opportunity to express its sincere appreciation to the members of the Faculty through whose cooperation and efforts the success of these meetings has been made possible. Special thanks are extended to the members of the Subcommittee on Health Evaluation Tests who have worked so diligently in providing this worthwhile opportunity for all members of the Faculty; and to the members of the Faculty staff who also have given so untiringly of their time to the numerous details involved in the Annual and Semiannual Meetings.

Respectfully submitted,
Joseph D. B. King, MD, *Chairman*
DeWitt E. DeLawter, MD
Arlie R. Mansberger, Jr., MD
John B. De Hoff, MD
Ernest B. Nuttall, DDS

PUBLIC RELATIONS COMMITTEE

Mr. President and Members of the House of Delegates:

The committee has held two meetings during the past year, at which considerable business has been transacted.

A Public Speaking Seminar was held on March 13, 1969 in the Faculty Building. This has become an annual program, but this year it was conducted by the American Medical Association rather than Smith, Kline and French Laboratories.

A Medical Assistants' Seminar was held in May, 1968 with great success. Plans are being made for another such program in 1969.

The assistance of the Woman's Auxiliary has been requested in two areas; in establishing lists of foreign-speaking hospital staff members, or community citizens who would help out in a situation involving a foreign-speaking patient, or perhaps deaf-and-dumb patients; and in organizing an Annual Nurses Recognition Day. These programs will probably be implemented on the county level.

A program of Citizen Service Awards has been initiated through component societies, whereby community citizens who have contributed to the general health of the community, or given outstanding service to the medical profession, will be recognized by the presentation of a certificate. Guidelines for selection of nominees have been issued to component societies.

Component societies have been requested to initiate School Health Coordinating Councils, to work closely with local Departments of Education and Health and PTAs. The School Health Council works on the state level with the Departments of Education, Health, and Mental Hygiene, and coordination at the "grass roots" level is desired.

After first rejecting support of the Health Manpower Resources Program, the committee heard a request by Health Council for reconsideration. Opinion was reversed, after learning more details of the program, and the Executive Committee was requested to give its approval. This was given. No financial support is being requested at this time.

Request from Radio Station WFBR for approval of the broadcast, "Doctor's House Call" to be sponsored by a chain pharmacy, was denied.

Respectfully submitted,
Richard A. Young, MD, *Chairman*
Manning W. Alden, MD
Earl M. Beardsley, MD
Jean O. Feys, MD
James M. Hitzrot, II, MD
Robert B. Goldstein, MD
Clayton Norton, MD
George Sharpe, MD
E. Roderick Shipley, MD
Bernard Gordon, DDS
Mrs. Martin Strobel

UNIVERSITY OF MARYLAND CHAPTER, STUDENT AMERICAN MEDICAL ASSOCIATION

Mr. President and members of the House of Delegates:

SAMA entered a new era of leadership on the medical campus this year by being stimulated by the hormones of competition. SAMA attempted to expand the broad base of activity which it already possessed. The words, concern, commitment, and action we hope characterize our ideas and endeavors on the Maryland campus.

Just as it was necessary for SAMA to provide a broad range of services to its members, it was also mandatory that SAMA serve the community. The first aspect which we have continued to do for several years has been high school visitations. Several of our first schools visited were primarily in the counties; Calvert County, Montgomery County, and the area high schools in Baltimore city. The people we speak to each year seem to become more aware of the medical community and the medical profession, and the questions that are asked are more challenging than they have been in the past.

When I was first making visitations, it seemed that they were asking how to get into medical school, and what you should take in college. Today, the questions seem to be on heart transplants, immunology, and the various aspects of the highly complicated technical fields. We attempted at one time to establish a closer liaison with the Medical-Chirurgical Faculty so that we might be able to take a physician along with the student, to answer the more difficult and complex questions. It has been in the planning, and unfortunately, it wasn't successful this year. Possibly, in the future, we may be able to get the program to the point where a physician could go with us and speak and represent both the Medical-Chirurgical Faculty and the University of Maryland.

The second major function is Career Day which will be held May 10. Anyone interested is more than welcome to come. We will provide a free lunch and you will have an opportunity to meet high school and college students from our area and the surrounding states. Each year we have invited mainly high school students. We've broadened it this year to include college students, and college and high school counselors. It seems there is a break in communications between what our admissions committee tells the students and what the high school and high school guidance counselors and the deans of the various colleges communicate to the students. We feel we might be able to bridge this gap if we are able to bring them to the university, show them the university, and speak with them informally at lunchtime. Dr. Young, we hope, will also be there from the Medical-Chirurgical Public Relations Committee.

More on a service and educational level has been our movie program which has been sponsored by Upjohn. Upjohn has put together approximately 50 movies on various aspects, ranging from stroke, to cardiovascular surgery, to complex discussions on hypnosis, and the delivery of a baby by cesarean section. These movies have been well attended, primarily by freshman and sophomores. They've been running since the beginning of January and will continue to run 'til the end of the year. There are about 150 medical students that either eat their lunches to cesarean sections or use free time to watch the very interesting movies.

Our speaker program has been more successful than in the past due to an increase in funds allotted to us from another organization and several drug houses. We were able to get Dr. Hillard Jason from University of Michigan, Dean of Medical Education (Medical Education is the hottest thing on our university campus and most other university campuses around the country). Dr. Jason was kind enough and gracious enough to meet with several students and faculty members of the university for informal discussion.

We were able to discuss topics ranging from student participation to his feelings on how curriculum should be run. It was a pleasant interchange and an enlightening one. Dr. Jason then spoke before the rest of the students on his feelings on medical education—what we hope to get out of medical education in the future.

This year it seems that more medical students desire to go abroad for summer electives, or to take the program that the University of Maryland is offering, and spend this time either in another university in the United States or over in Europe. SAMA, as a service to its members, decided to run a foreign fellowship program in which students from the previous senior class are called upon to speak about their experiences in Europe and the United States. It was enlightening in that it was a student approach to how to get around the faculty's requirements, so to speak, or how to graciously convince the dean to let you out of some specialty in surgery, and let you go take your medicine elective, or vice versa.

SAMA is concerned about its members, their feelings, and their wishes, and yet we are committed to present programs which would also broaden our education. Last year at our presentation here, we spoke about community health, since that was of more current interest than medical education. This year, I believe it's medical education, but we've also been criticized as being one year behind so we got into both programs and our educational program is what we call the emergency room medical advocate program. It seems that one of the main criticisms in major university schools that are in the inner city, is the poor way, or the inequitable way, that patients are treated in the emergency rooms. The cry of the freshman and sophomore medical student is that it's a herd that is placed against the wall and one by one they're seen by so-called physicians, junior students, or senior students and are never seen by a doctor.

We thought that it would be educational for freshman and sophomore medical students to spend some time in the emergency room. We thought it would be good for the students to establish a rapport with the community. In this medical advocate program, or health care delivery system, freshman and sophomore students on weekends, of their own accord and without any reimbursement or any threats or any grades attached to their service, are seated in the emergency room, and welcome and greet the patients as they come in. They don't take a history and they don't perform a physical examination. Their sole function is to talk to the patient when he comes in. It turns out that they are doing what seems to be a psychiatric clerkship in that they're speaking with the patient about his problems concerning his illness, and why he waited until 11:30 at night to come to the emergency room.

The goal of this pilot program is to have it incorporated into the community medicine program that is being developed by the university. The fellows that have worked in the emergency room have gained a tremendous amount of experience in interviewing or speaking with patients and have overcome some of the fright that some of my class members in the junior year had when they first walked on the wards and had to take histories and do physicals. The students are not restricted to the outer waiting room and are encouraged by the house officers, who are more than willing to speak to them and teach them, to traverse the green door and see the patients as they're being treated.

The second program we've initiated is student participation in the medical curriculum changes. Spurred on by some of Dr. Jason's suggestions, and previous suggestions by our own classmates, we presented to the curriculum committee a suggestion that some students be placed on the committee. I'm pleased to say that this year the committee decided to choose two students who will sit on the school's curriculum committee. In addition to this, one of the staff members of the university, Dr. David Simpson, is the President of Eastern Thoracic Association, and a curriculum committee will be created to discuss courses in pulmonary and respiratory medicine. They have decided to work through SAMA chapters, and to choose members who will meet at Saranac Lake in the middle of June to discuss curriculum changes in regard to pulmonary medicine.

This is a huge step forward in student participation in the medical curriculums. There have been different discussions as to whether a freshman or sophomore student is capable of deciding whether he should take an elective in urology or he should continue in medicine. I don't believe that he will be called upon to make de-

cisions, but his representation and his ideas, I think, will be more thoroughly considered.

Our two largest publications are the *New Physician* and the "Asclepian." The *New Physician,* which students, residents and some sustaining members receive, has taken on new dimensions in publication. Previously, it was a poor imitation of the *New England Journal of Medicine.* As it stands today, there's no relation, or very little relation to a medical journal, and no relation whatsoever to the *New England Journal.* There are more culturally related articles, several topical articles on drug abuse and addiction, and it's turned into a rather interesting publication for medical students. The "Asclepian," which is our school newspaper, is published under the auspices of SAMA. It's not restricted. Any member can write into the paper, and we request and solicit articles from staff and faculty members.

I was fortunate enough to be a member of one of the public relations committee meetings here and had a chance to participate in an informal interchange with the members of that committee. I was pleased to see that the committee is intimately aware of several of the problems in the schools and is concerned with increasing help to these schools.

Med-chi has made one gracious contribution and I thank you again for your support. I hope that through more careful interchange we might be able to establish a physician and student relationship in high school interviews, and that possibly you might be able to come down to our meetings more often than in the past.

With your continued aid and guidance, I'm sure SAMA will act to see that the interest of its members in the medical profession and community are fulfilled.

Respectfully submitted,
DAVID TAPPER, *President*

THE WOMAN'S AUXILIARY TO THE MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

Mr. President and Members of the House of Delegates:

Your Woman's Auxiliary appreciates the privilege of reporting to you on this year's accomplishments and aspirations.

In addition to continuing our many on-going programs, we initiated and pursued an amazing number of new projects, with Faculty approval.

An Ad Hoc Committee on Children and Youth was established, with emphasis on stemming the tides of violence engulfing our youth via mass media. We joined forces with other community organizations and medical auxiliaries nationally, for an impact that already has begun bearing fruit. A letter-writing campaign directed at leading radio, television, and movie producers, as well as newspaper editors and feature writers, was instigated. Joint conferences and forums were held with school, religious and other community leaders, students, columnists and interested groups. The culmination, to date, has been the keynote speech on this topic at our annual meeting, followed by an exciting panel of knowledgeable experts in this field. (We were gratified, too, to have many national, regional and out-of-state guests accept our invitation to attend this annual meeting.) Steps have also been taken toward the appointment of some Maryland Auxilians to the President's White House Conference on Children and Youth in 1970, hopefully.

For the first time, we conducted at the state level all six workshops paralleling those at the national level, in an attempt to bring back to our counties some of the wealth of information, fresh ideas, and enthusiasm imparted to us. For the first time, too, Maryland had 100% participation at the Regional Workshops in Boston covering American Medical Association-Education Research Foundation fund-raising techniques, Community Health needs for home aid services, Disaster Preparedness-Safety programs, imaginative recruiting projects for Health Careers, interdependent Program and Membership planning, and the vast area of creative Mental Health approaches.

We are now publishing a new brochure descriptively listing national's ten outstanding researched package programs on urgent areas of health concern. These are available under our auspices for use by communities according to their needs. Our national periodical, "M.D.'s Wife", has taken note of our phenomenal success, with such package programs on Health Careers and Mental Health, already presented before twenty-six interested county groups numbering well over a thousand people per package this year. Our "Block Mother Program", to safeguard young children en route to and from school, is being put to good use locally, and we are confident that our other excellent programs on Drug Abuse, Tobacco, Alcohol, Teen-Age Venereal Disease Control, Safe Babysitter Training and Homemaker Health Services will be equally well employed when better known. Another program, on Sex Education, is being widely used with excellent results, in cooperation with our county schools. A new centralized library of these programs is now housed at Med-Chi for prior inspection and project selection.

We conducted a state-wide survey of home-centered health care services available to shut-ins, the elderly, and families in danger of disintegration for temporary lack of a homemaker. This pointed up the glaring lack of centralized information, as well as area gaps in meals services, friendly visitors, and home aides.

In conjunction with our chosen theme for the year, "As Others See Us", we circulated a questionnaire inquiring into our members' involvement in other community activities. Although limited, the response impressively confirmed that doctors' wives are indeed the active and concerned ambassadors of their busy husbands in community service.

At the requests of your Public Relations Committee, we suggested a means of your honoring nurses, and we have launched an effort to enlist "Translation Team" volunteers in hospital communities. These lay or professional people would be called upon to help alleviate communication problems which sometimes arise with foreign patients, particularly outside urban areas, and might well be an additional important mental health factor in their recovery. Anyone willing to act as such an interpreter should list his name with us; we'd welcome your help.

Our auxilians have acted as hostesses for the medical society in many new, as well as continuing, programs at both local and state levels. We have manned your coffee booths and exhibits; immunology, testing, and detection centers; medical seminars, luncheons, library tables, and such. We were also pleased to provide a list of our widows, as requested, for inclusion in your Med-Chi Membership Directory.

We co-sponsored a superior new color film, "The Many Hats of Laurie and Harriet," produced by the Health Department, for nurse recruiting, and we were proud of its selection for showing at the national auxiliary meetings in July at the Waldorf-Astoria in New York. (We are also planning to have a "Show and Tell Exhibit" on Tuesday of those meetings and would welcome your attendance.)

Our Handbook and Bylaws were revised, of necessity, and a resolution submitted to confer honorary membership on a second deserving auxilian.

For a real "change of pace," we tried a new American Medical Association-Education Research Foundation Fun(d)-Day approach—a highly successful "Day at the Races" at Laurel last fall, supplemented by "Mini-Shares for ERF" this spring. (To augment our AMA-ERF coffers, our component auxiliaries staged numerous successful theater and card parties, fashion show-luncheons, sold Christmas and special occasion cards, note paper, and the "Doctor's Wife" rose bushes. Cecil County came up with a new fund-raising venture—needlecraft lessons! By all these means, we look forward to another record year when the final tally for ERF is made. These funds (almost $6,000) were applied this year toward our two medical schools' needs and the AMA Biomedical Research Institute.

Our programs have been unusual and timely. Our Semiannual Meeting speaker, Dr. Eareckson, was so well received that a spontaneous contribution was collected for his "Bethany House" project for wayward boys in need of a wholesome home atmosphere. Following an outstanding feature article in our excellent newsletter, "Hygeia Filiae" (which emphasized the medical image of community service in keeping with our chosen theme for the year), this venture attracted national notice and a further feature write-up by the Sunpapers.

We are also very happy about five fledgeling component newsletters this year, all serving a fine function in communication. (Other means of coordination and communication included the state president's visits to the counties as well as neighboring states, regional and national meetings; each component county's representation on the State Auxiliary Board which met regularly; and, of course, our state publications.) We circulated copies of our Governor's Proclamation of Doctors' Day to all the component auxiliaries and submitted it for publication on the auxiliary's page in the State Medical Journal for the first time.

So much for what has been different this year. Our pill-packing parties for overseas shipments have continued, but these are about to be "phased out" because of high shipping costs, supervision problems, and some customs restrictions. Our other International Health activities will continue unabated, with johnny coats, leper bandages, books, soap and clothing being shipped; international medical personnel and guests entertained.

Among our many other activities, Baltimore County auxilians visited the House of Delegates in Annapolis with appropriate acknowledgement of their attendance arranged, while the City conducted a telephone survey of the doctors for the Community Chest-Red Cross United Appeal, as requested. Washington Countians were delighted with their showcase of medical memorabilia set up for the Doctors' Library at their County Hospital.

Another of our counties (Harford) is preparing slides with commentaries on the many varied health career opportunities within its borders. Our Future Nurses and Health Careers Club activities continue to expand in the almost 60 high school clubs throughout the state which we help guide and finance. Our scholarships to students in health careers have more than doubled in the past year. Baltimore city alone has awarded about $22,000 to medical and paramedical students since 1956, with about one fourth of this given during the past year, interest-free. Prince Georges is having a "Psychedelic Costume Party" to raise more funds for its scholarships.

Allegany members are active on many councils and programs (the latest involves adoptions) for which they have earned the community's respect. Wicomico County, too, has taken an important leadership role in community education and medical hospitality, as it attempts to decrease the medical manpower shortage in that area. Carroll County's Bedside Library is now nicely under way. A number of our women are on the advisory committees for nursing programs at county community colleges, in county community action programs, on Mental Health and Social Service Boards. Many county auxiliaries have given strong volunteer and financial support to sheltered workshops for the handicapped, the Mental Health Society, psychiatric institutions, local hospitals, a sanitorium, libraries, day care and rehabilitation centers.

Our Disaster Preparedness—Safety Committee has done its share toward making this a "Safe not Sorry" year through support of numerous fire, clean-up, traffic safety and poison-prevention community projects.

We had 100% participation of all our components in the observance of Doctors' Day, I am pleased to report. The means employed were varied: dinner-dances, cocktail-buffets, bouquets of carnations and patient-tray favors in hospitals, AMA-ERF contributions, radio and television spots in some counties, a Central Pratt Library window display, a hospital luncheon with auxiliary members as hostesses, contributions of books, health periodicals, posters and completion of "The History of Medicine in Wicomico County."

In hopes of preparing both husband and wife for future practice and productive medical society participation, we have sponsored and worked closely with the Woman's Auxiliary to the Student AMA (WASAMA), whose president also reported on their fine year at our meeting yesterday.

Our hospitality has been ample, our archives up to date, our finances in order, and we have enjoyed excellent public relations and coverage from the press.

It would be splendid if more of our components could emulate the sizeable increase in membership (26) ef-

fected by Montgomery County this year. Our current membership approximates 940 in our 11 organized auxiliaries covering 13 counties and Baltimore City, with "members-at-large" from ten other unorganized counties. We are working hard at "making membership more meaningful" and believe that we have taken giant steps again this year. It is our hope that our image, "As Others See Us," has grown more lovely during the year and that more doctors and their wives will be eager to swell our ranks. Here again we need your help to fulfill our tremendous potential.

We are grateful for your continued generous assistance and encouragement; we are hopeful, too, that we have been a real Helping Hand in the Big Picture of Progress for both our organizations, which share the same goals.

Respectfully submitted,
MRS. H. LEONARD WARRES, *President*

TREASURER'S REPORT
PROPOSED BUDGET
ESTIMATED EXPENDITURES
1969

	Budget 1968	*Actual through Nov. 1968*	*Budget 1969*	
Auditing	$ 1,500.00	$ 1,800.30	$ 2,000.00	
Legal	5,000.00	3,965.00	5,000.00	
Contributions	700.00	100.00	700.00	A*
Fuel	2,000.00	1,491.79	2,000.00	
Gas, Electricity, Water	5,000.00	5,105.30	5,000.00	
Telephone & Telegraph	5,000.00	4,479.69	5,000.00	
Postage	6,500.00	5,850.98	6,500.00	
Household & Janitorial	1,600.00	1,894.31	1,600.00	
Property Maintenance	2,500.00	4,377.56	3,000.00	B*
Insurance	2,000.00	1,959.51	2,100.00	
Equipment Rental	3,500.00	3,850.71	4,000.00	
New Equipment	2,500.00	2,850.79	1,500.00	
Equipment Maintenance	1,000.00	374.78	1,000.00	
Stationery & Supplies	4,000.00	3,203.49	4,000.00	
Salaries	169,226.00	156,034.47	184,718.00	C*
Social Security	6,316.00	5,608.56	7,619.00	D*
Unemployment Compensation	2,000.00	243.11	1,000.00	
Employee's Insurance Program	3,000.00	3,331.52	3,000.00	
Employee's Pension Program	10,000.00	13,242.26	10,000.00	
Supplementary Hours Exp.	2,500.00	2,141.07	2,500.00	
Travel	6,500.00	6,112.50	7,500.00	E*
Printing	4,500.00	4,983.72	4,500.00	
Legislative	5,000.00	5,771.36	5,000.00	F*
Library	5,000.00	2,665.49	5,000.00	G*
Journal Expense	85,000.00	80,081.76	85,000.00	
Annual & Semiannual Meetings	23,000.00	27,461.18	25,000.00	
Interest to Coggins Fund	5,500.00	5,500.00	0.00	
Presidential Fund	1,000.00	164.05	1,000.00	
Woman's Auxiliary	1,000.00	1,000.00	1,000.00	
Miscellaneous Expenses	3,500.00	2,449.45	3,000.00	
TOTAL	$375,882.00	$358,095.16	$389.237.00	

* See Explanatory Notes

ESTIMATED INCOME
1969

	Through November 1968	*Budget 1969*
DUES		
Baltimore City Medical Society	$106,245.00	$106,000.00
Counties	120,120.00	120,000.00
Baltimore City Dental Society	1,865.00	1,800.00
	$228,230.00	$227,800.00
RENTS & SERVICES		
Baltimore City Medical Society	$ 25,943.00	$ 26,0000.00
Board of Medical Examiners	5,250.00	6,300.00
Maryland League for Nursing	385.00	420.00
Med-Chi Insurance Trust	5,635.00	11,475.00
Other	125.00	0.00
	$ 37,338.00	$ 44,195.00
INVESTMENTS		
General Purpose	$ 3,757.34	$ 4,000.00
MEDICAL JOURNAL	76,975.59	85,000.00
ANNUAL MEETING	21,250.50	20,000.00
OTHER	9,605.14	8,500.00
TOTAL	$377,156.57	$389,495.00

COMMENTS ON 1969 PROPOSED BUDGET—MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

A. *CONTRIBUTIONS:* Student American Medical Association:

National Chapter	$100.00
University of Maryland Chapter	250.00
National Society for Medical Research	50.00
Miscellaneous	300.00
	$700.00

B. *PROPERTY MAINTENANCE:* The increasing costs of repairs and maintenance of the Faculty property accounts for the $500. increase in this item.

C. *SALARIES:* A general revision in Salary Ranges took place during 1968. The Faculty, as is all organizations and individuals, is faced with increasing costs of hiring personnel. In addition, one more secretary position was authorized in 1968, of which only a portion of the year's salary in the Actual 1968 figures is included. Normal increments for 1969 are also included.

D. *SOCIAL SECURITY:* An increase of $1,300 is included due to an increase in the Faculty's portion of Social Security contributions.

E. *TRAVEL:* Authorizations and attendance at the following meetings:

Professional Convention Management Association and Medical Exhibitors Association, Atlanta, Georgia, January 5-7, One Staff Member

National Congress on Socioeconomics of Health Care, Chicago, Ill., March 28, 29, 1969, One Staff Member

National Medicolegal Meeting, Las Vegas, Nev., March 14, 15, 1969; One Staff Member

Medical Society Executives Association (1 day) and American Medical Association Annual Meeting (5 days), New York City, July, 1969—One Staff Member, Three Delegates and Senior Alternate Delegate

Medical Society Executives Association (1 day) and AMA Institute (2 days), Chicago, Ill.—Two Staff Members

American Medical Association Clinical Meeting, Denver, Colorado (4 days), November/December, 1969—One Staff Member, Three Delegates and Senior Alternate Delegate

Maryland participation in Southeastern States Hospitality Room at AMA Annual and Clinical Sessions

Attendance of Committee and Subcommittee Chairmen; as well as Faculty designees at meetings sponsored by AMA and other associated organizations. These are authorized on an individual basis by the Executive Committee

Travel (mileage) throughout State for staff persons in visits to component societies and other Faculty business

Library: International Congress on Medical Libraries, Amsterdam, The Netherlands, June, 1969

Special Library Association, Montreal, Canada, June, 1969

Medical Library Association, Louisville, Ky.

Regional Library Meetings, Bethesda, Md.

Any TRAVEL for which the Faculty is reimbursed by the AMA or other affiliated, allied or associated groups is approved without reference to the Executive Committee.

F. *LEGISLATIVE:*

Operation of First Aid Room	$1,000.00
Legislative Newsletter (5-6 issues)	3,000.00
Copies of Legislative bills	300.00
Legislative Expenses (mileage, meals, etc.)	500.00
Legislative activity on federal level	200.00
	$5,000.00

G. *LIBRARY EXPENSES:*

Total, per library budget	$32,500.00	
Less items included in other budget headings (salaries, social security, etc.)	27,500.00	$5,000.00

Journal subscriptions, books, binding, etc., are paid for from designated fund income and are, therefore, not included in these figures.

Respectfully submitted,
KARL F. MECH, MD, *Treasurer*

The Auditor's Report will appear in a future issue of the JOURNAL.



Reports of the following Committees will be formally presented at the Semiannual Session, September 1969. Preparation of these reports in sufficient time for printing and distribution prior to the Annual Session was not possible because of the unusually early date for the Annual Session, as well as the State General Assembly being in session until late March.

American Red Cross Blood Research Program
Board of Medical Examiners
Legislative Committee
Liaison Committee
Mediation Committee
Medical Economics Committee
Medicolegal Committee
Occupational Health Committee
Professional Medical Services Committee

These reports appear on the following pages.

BOARD OF MEDICAL EXAMINERS OF MARYLAND

Report for the year ending December 31, 1968

Mr. Chairman and Members of the House of Delegates:

The Board of Medical Examiners is composed of the following members whose terms expire on the dates indicated:

John J. Curry, MD 1969
Vernon H. Norwood, MD 1969
Elmer G. Linhardt, MD 1970
William L. Stewart, MD 1970
J. Roy Guyther, MD 1971
Gerald A. Galvin, MD 1971
Karl F. Mech, MD 1972
Archie R. Cohen, MD 1972

As the terms of John J. Curry, MD, and Vernon H. Norwood, MD, expire June 1969, two members to serve until 1973 are to be elected at the meeting of the Medical and Chirurgical Faculty.

J. Roy Guyther, MD, was appointed to fill the vacancy created by the resignation of John H. Hornbaker, MD, whose term would have expired in 1971. Dr. Guyther, or someone else, is to be elected to fill the vacancy created by Dr. Hornbaker's resignation.

Examinations given during the year show the following results:

Applications received for examination		592
Second-year students examined and re-examined	56	
Postponed, withdrawn or did not appear	101	
Failed to complete	1	
Not eligible for license		158
Examined in second part of examination	81	
Complete examination		245
Re-examined		108
Eligible for license		434
Passed–American Graduates	135	287
Passed–Foreign Graduates	152	
Failed–American Graduates	25	147
Failed–Foreign Graduates	122	

American Graduates who failed are as follows:

Johns Hopkins–1; Howard–19; Georgetown–1; U. of Maryland–1; Meharry–1; Phil. Osteopathic School–1; Puerto Rico–1.

Licenses issued after examination	287
Licenses issued by endorsement of other State's Licenses	248
Licenses issued by endorsement of National Board Certificate	325
Total Licenses issued	860
Licenses revoked	1
Licenses suspended	0
Licentiates certified to other states	351
Copies of Licenses issued	16
American graduates examined and re-examined	314
Foreign graduates examined and re-examined	237
Foreign graduates approved for examination	264
Written inquiries from foreign graduates (approximately)	750
Office interviews with foreign graduates (approximately)	375
Telephone inquiries from foreign graduates (approximately)	1700
Telephone inquiries concerning registration of physicians	1500
Registration certificates issued from 1/1/68 to 12/31/68	933

Licensed by Special Examination

Richard Rowe, MD—1/29/68
Charles C. Berdjis, MD—2/16/68
Martin Andrew Nelson, MD—4/19/68
Fayek G. Yassa, MD—4/19/68
Virender K. Saini, MD—5/17/68
John Harold Painter, MD—6/21/68
Peter C. Luchsinger, MD—12/20/68
Mieczyslaw Mirowski, MD—12/20/68

Revocation of Medical License

The medical license of *Ghulam M. Nasim,* was revoked on June 4, 1968 for obtaining licensure by fraudulent, deceptive and erroneous means. The case has been appealed.

Probation

Elizabeth Reese Wilkens, MD, was placed on probation with instructions to appear quarterly at Executive Committee meetings for a term to correspond with the court probation, after being convicted for selling "pep pills." Dr. Wilkens notified the Board on October 22, 1968, that she was retiring from the practice of medicine.

Reprimanded

Luis Cuza, MD, has been requested to appear before the Executive Committee quarterly to give an account of his professional activities. This action was taken after receiving complaints that he was indiscriminately selling dangerous drugs.

Carlos Arrabal, MD, appeared before the Executive Committee on January 19, 1968 and October 18, 1968, and gave satisfactory reports of his professional activities.

William Howard Philpott, MD—The Board notified Dr. Philpott that it considered the evidence given it, and it is felt he probably transgressed the Medical Practice Act for advertising.

Stuart A. Perkal, MD, and James F. McCarter, MD—A letter dated May 6, 1968 from Wolcott L. Etienne, MD, chairman of the Mediation Committee of the Medical and Chirurgical Faculty, to one, Stuart A. Perkal, MD, was read in which it was stated that on September 28, 1967, the Faculty's Mediation Committee had deliberated on the matter of his participation in

the alleged abortion by James F. McCarter, MD, of Cambridge, Maryland. The Secretary was empowered to make a resumé on the action of Stuart A. Perkal, MD, and James F. McCarter, MD, and attach such resumé to their permanent records. This resumé is to include the Mediation Committee's censure.

Unlicensed physicians—No unlicensed physician should be practicing medicine in the State of Maryland other than as an intern or resident in an approved training program.

John Gordon Rennie, MD—The Board was notified by the Federation of State Medical Boards that the medical license of Dr. Rennie was revoked in the State of California, execution of order of revocation stayed and respondent placed on probation for five years, and that he was convicted of violations of the statutes of the State of California regulating narcotics. The Board unanimously voted to proceed with the necessary administrative procedures to hold a hearing for the consideration of suspension or revocation of his license to practice medicine in the State of Maryland.

George Beck, MD—The Board unanimously voted to proceed with the necessary administrative procedures to hold a hearing for consideration of suspension or revocation of his license to practice medicine in the State of Maryland. Dr. Beck was licensed by this Board on July 16, 1953.

William Eisner, MD, has been requested to appear before the Executive Committee with regard to his current medical practice, and the use of unlicensed physicians in his office. Dr. Eisner was licensed by this Board on May 13, 1942.

Alfred R. Lapin, MD—Pine View Nursing Home—Dr. Lapin was reprimanded for using unlicensed physicians in the Pine View Nursing Home, and advised that any further participation in this type of activity would result in consideration of suspension or revocation of his Maryland medical license.

S. A. Bowman—Violation of the Medical Practice Act. This has been referred to the State's Attorney for Wicomico County for action.

Ballentine & Shub Laboratories—It was the decision of the Executive Committee that the Ballentine & Shub Laboratories were in violation of the Medical Practice Act. They were notified to cease and desist such practices in the future.

Applications for restoration of license

Webster Sewell, MD, requested permission to take the State Board examination for licensure. The Board granted him permission to take the regular written examination on or after June, 1968.

Grayson Spencer Waldrop, MD, requested the Board to reinstate his Maryland medical license. This request was denied.

Sixty-Fourth Annual Congress of Medical Education and Licensure

Doctors Vernon H. Norwood, Walter C. Merkel and William L. Stewart attended the Congress held in Chicago, Illinois, February 9-14, 1968. Member Boards voted to revise the dues structure and this Board was billed $300.

Cuban Refugee Physicians

It was the decision of the Board that Cuban (refugees) physicians be treated no differently than any other foreign graduate in that they be required to complete two years of hospital training in the United States in either internship or residency programs, with one of these years being spent in Maryland or one of our borderline states before being eligible for licensure in Maryland (along with other requirements). This became effective July 1, 1968.

Medical Ethics

Each applicant for examination is now supplied with a copy of "Principles of Medical Ethics" with a notation to the effect that questions on its contents may be given on the examination.

Court Registration

The Board was informed that the court registration fee for medical licenses was increased from $2 to $5, effective July 1, 1968.

Change in Reciprocity procedure

The Executive Committee may accept an applicant for reciprocity even if one or more grades are below 75%, only with states having reciprocity with Maryland and the National Board candidates. Applicants from states with no reciprocity with Maryland must meet not only the general average of 75%, but grades in each of the subjects must be 75% or above.

Rules of Procedure for Board Hearings

Rules of Procedure for Board Hearings were established in accordance with the Administrative Procedure Act of Maryland under Article 41, Sections 245, 246, and 251 of the Annotated Code of Maryland (1967 Cumulative Supplement).

Tuberculin Testing Screening Center

It was the decision of the Board that under the jurisdiction of the Tuberculosis Association, a registered nurse may administer the test. The interpretation of the test by a nurse is in violation of the Medical Practice Act.

Paramedical Licensure

John M. Dennis, MD, a member of the Medical and Chirurgical Faculty, met with the Board to give them information on proposed legislation for paramedical licensure in Maryland of Radiologic Technologists. The Board is interested and concerned with this legislation, and at the moment, it is in the interest of the welfare of the general public. Dr. Dennis will keep the Board informed of the progress made and will present any legislation for consideration prior to its submission to the legislature.

Increase in Reciprocity Fees

The fee for licensure by reciprocity or endorsement was increased from $50 to $100, effective January 1, 1969.

Triennial Registration

It was the decision of the Board that the triennial registration of physicians be performed by one third of the total registrants being registered each year.

Respectfully submitted,

ELMER G. LINHARDT, MD, *Executive Secretary*

LEGISLATIVE COMMITTEE

Mr. President and Members of the House of Delegates:

There were over 100 bills of considerable importance to the profession introduced into the General Assembly at the 1969 session. Members of the Legislature are becoming more and more cognizant of the role of the Medical and Chirurgical Faculty in this area. Appreciation is expressed to all those members of the Faculty who gave of their time and knowledge to go to Annapolis to represent the Faculty.

The Assemblyman, issued at intervals during the session, carried details of bills of interest to physicians. A listing of the primary bills affecting medicine is appended to this report.

A request was made by this committee and approved by the Executive Committee that Faculty members refrain from appearing at committee hearings in Annapolis as representing the Faculty, unless they have been designated to do so. This, of course, does not limit the individual's right to present his own, personal views.

The First Aid Room in the State House was again maintained for the convenience of members of the Legislature during the 70-day session. As in past years, this service was sponsored by the Anne Arundel County Medical Society, the Anne Arundel General Hospital, and the Faculty. However, this year, a new service was added. Members of the Maryland Academy of General Practice gave a day of their time, to be available to members of the Legislature, visitors, and staff who might need care, and at the same time, to become more familiar with legislative processes. Senate Resolution 88 was adopted which expressed appreciation to the physicians of Maryland for this service.

A legislative subcommittee was initiated to study the Licensure of Paramedical Personnel. Several meetings were held, after which a bill was submitted to the Legislature which would license radiologic technologists. This was referred to the Legislative Council (the between-session arm of the General Assembly) for further study. It was decided that an attempt to license medical technologists would be postponed, at least until the next (1970) session.

A legislative subcommittee to consider physician-patient privileged communication legislation met once to discuss a proposal by a legislator that such a bill be introduced. It was agreed to table this matter until such time as more persuasive evidence with regard to the need for such legislation could be presented.

Another subcommittee was formed to discuss implied warranty legislation. There was one meeting of this group and the result was that a bill prepared by the Faculty's legal counsel was presented for introduction in the General Assembly. After committee hearings, it was felt that the bill should not be amended and a request was made that the committee kill it.

Another special legislative committee to discuss a proposal for a Board of Dispensing Opticians met with representatives of the Optician, Optometrist, and Ophthalmologist organizations. A draft of legislation to license dispensing opticians was presented and revised several times. However, because of many difficulties and differences of opinion, the bill was never presented to the Legislature.

Because of the passage of the Anatomical Gift Act legislation in 1968, and impending amendments in the 1969 session of the General Assembly, a Medical Tissue Donation Committee was formed. This committee met several times for the purpose of planning the coordination and centralization of files and registry of all types of organs or human tissue so that maximum utilization of available tissue may be made. Forms have been designed for the public to use in requesting donation of organs either pre- or post-mortem. However, in view of the permissive language of the Anatomical Gift Act, one of the forms may be revised. It is anticipated that the master form will be kept at the headquarters of METIC (Medical Transplant Information Center) and a plasticized, wallet-sized card will be issued to the donor to carry with him. Telephone directory listings were prepared by members of the committee.

Several component societies held dinner meetings with their local representatives in the Legislature. These dinner meetings have proven very successful and more such personal contact is urged.

One meeting of the Legislative Committee was held with physicians of five counties attending via the MEDIC network. This innovation met with enthusiasm and will be continued in the future. Each component society was requested to name a liaison member with this committee in order that information can be transmitted to each society quickly, and this, too, will be continued as a policy of the committee.

Respectfully submitted,

B. MARTIN MIDDLETON, MD, *Chairman*
STEPHEN K. PADUSSIS, MD
J. MORRIS REESE, MD
ROLAND T. SMOOT, MD
FRANCIS J. TOWNSEND, MD
WILLIAM A. WILLIAMS, MD

APPENDIX

Senate Bill 149, after amendments by both Senate and House, was enacted into law in the final days of the Legislative Session. Effective on July 1, 1969, individuals may incorporate and take advantage of tax situations that heretofore were not available to professional persons.

The Faculty has under consideration a proposal to assist in any legal actions that may have to be taken to obtain a District Court ruling that the above is permissible under IRS regulations. Court rulings already in existence are not necessarily applicable to the District in which Maryland is located.

A bill to *define blood as a service* and not a product *(Senate Bill 75)* met with opposition in the Senate Economic Affairs Committee. This was a pre-filed bill and the U.S. Supreme Court ruling on this subject had not been received at the time it was pre-filed. Before committee action was taken, the Faculty requested that the bill not be amended and that it be killed in committee. This was done.

House Bill 240 established the principal that the Board of Education, in cooperation with the Board of Health, promulgate Rules and Regulations regarding required immunizations of school children in order for them to enter school. This was enacted by the Senate in the closing hours of the session.

House Bill 346, the Generic Prescribing Bill, with minor amendments, was adopted by the House and Senate. A communication in this regard will be sent to all members at a later date. The bill requires the pharmacist to fill Medicaid prescriptions with a generic equivalent from the State Department of Health formulary, unless the physician indicates otherwise.

House Bill 385 gives authority to the State Board of Health and Mental Hygiene (now the Secretary of Health and Mental Hygiene—see below) to contract with nonprofit insurance carriers to provide health services to Medicaid recipients.

House Bill 512 requires the State Health Department to initiate a system of Peer Review in the Medicaid program. It also abolished the old "Council on Medical Care" whose duties are now being performed by the Medical Assistance Advisory Committee.

House Bills 850 and 851 were both enacted into law. They provide for *Express Consent and Implied Consent.* This legislation was part of the Governor's package in connection with traffic safety.

The Drug Abuse Control Act was also enacted into law at this session of the Legislature. It provides for establishment of an *Advisory Council on Drug Abuse,* as well as a Drug Abuse Authority. The Authority would have broad powers to, "promote, develop, establish, coordinate and conduct unified programs for education, prevention, diagnosis, treatment, after-care, community referral, rehabilitation and control in the field of drug abuse."

Senate Bill 404 provides for *creation of the post of Secretary of Health and Mental Hygiene,* at the same time abolishing the Board of Health and Mental Hygiene. The bill gives broad powers to the Secretary to reorganize the Departments of Health and Mental Hygiene.

The various medical and medically-related licensure boards are also placed within this new department, as are agencies such as, The Anatomy Board of Maryland, and the Board of Post-Mortem Examiners.

Senate Bill 512, patterned very much after the Commission on Medical Discipline, established a *Commission on Optometry Discipline.* It is our understanding that the dental groups have under consideration a similar commission for dental discipline.

Senate Bill 557 makes it unlawful for any company to mail unsolicited drugs to "resident," "occupant," or to named persons whose names are obtained from lists. An exemption was placed into the law for those individuals "who are licensed to disburse, prescribe, or administer such drugs."

Senate Bill 768 was also enacted into law, and provides for certain amendments to Maryland's Anatomical Gift Act, adopted at the 1968 General Assembly session.

Senate Bill 769 was enacted into law which requires that tissue banks and blood banks be licensed and be under the direction of a licensed physician.

More mail was generated to the members of the General Assembly on *House Bill 683* than any other single bill considered this year. This bill would have prohibited the use of Chloramphenicol except under certain circumstances; and would have also established penalties if physicians used this drug. In addition, the bill provided that if a patient developed any side effects from the use of the drug, that it would, *post ipso facto,* be considered malpractice and a civil award would be assessed as well.

This bill was given an unfavorable report by the committee and, therefore, failed to pass. There is no question that the flood of mail by physicians did much to convince the committee members of the ridiculous provisions of this bill.

LIAISON COMMITTEE

Mr. President and Members of the House of Delegates:

The entire Liaison Committee held only one main meeting during the 1968/69 year. The various subcommittees, however, reflect most of the activity of the committee and their reports follow.

Subcommittee on Medicine and Religion:

This subcommittee held several meetings, all attended by a representative of the AMA's Department of Medicine and Religion. A Theological Seminary Education Program was discussed in great detail, and it is the hope of the subcommittee that such a program can be implemented during the next Faculty year. There are four seminaries in Maryland, and it is anticipated that the component society where each seminary is located will work with the seminary in these programs.

The Memorial Hospital in Cumberland, held its annual Medicine and Religion Day in October 1968.

Because of the importance to the profession and the community, it is felt that the subcommittee should become a full committee of the Faculty. An appropriate bylaw amendment was adopted at the April 8, 1969, meeting of the House of Delegates.

A request has been made to the AMA for a new film, *A Storm-A Strife,* available on a long-term loan basis for use in Maryland.

It is hoped that the new committee will establish a Medicine and Religion Month to be promoted throughout the state.

A Workshop on Medicine and Religion is planned for next year. Each component society wll be asked to send a representative who will also act as a local liaison person for the committee.

Subcommittee on Pharmacy:

This subcommittee held only one meeting during the

year. It reported to the Mediation Committee information dealing with a physician permitting an unauthorized person in his office to dispense medication. The subcommittee also recommended to the Mediation Committee that direct telephone lines between physicians and pharmacists be declared unethical. This recommendation was adopted by the Mediation Committee and the Council.

Still under discussion within the subcommittee is an educational program directed at both the public and physicians in connection with drug abuse.

Nursing Liaison Subcommittee:

This group met on two occasions during the year. It approved an amendment to the Nurses Protocol dealing with nursing care in Intensive Care and Coronary Care Units of hospitals. This amendment was approved by the governing bodies of both the Faculty and the Maryland Nurses Association. Discussion continues in connection with the regulations and utilization of allied health personnel.

The *Nursing Home Liaison Subcommittee* held no meetings during the year.

Respectfully submitted,

DONALD W. MINTZER, MD, *Chairman*
MELVIN N. BORDEN, MD
ROBERT E. FARBER, MD
PAUL F. GUERIN, MD
JOHN H. HIRSCHFELD, MD
JOHN KEHOE, MD
HARRY W. DRESSEL, MD
WILLIAM J. PEEPLES, MD
JOHN F. SCHAFFER, MD
WILLIAM L. STEWART, MD
H. LEONARD, WARRES, MD
W. KENNETH MANSFIELD, MD
LEON R. LEVITSKY, MD

MEDIATION COMMITTEE

Mr. President and Members of the House of Delegates:

The Mediation Committee met monthly during the year concluded. A complete numerical listing of all cases coming before the committee, as well as before Component Society Grievance Committees, is appended at the conclusion of this report.

As in previous years, the committee was called upon to consider serious complaints against physicians. In addition, numerous queries regarding specific ethical problems were discussed and conclusions provided to the inquirer.

A Subcommittee on Narcotic Prescribing Practices was appointed to look into possible abuses of narcotic prescribing by certain physicians. Nine physicians were invited to meet with the subcommittee, and representatives of the U.S. Department of Narcotics and Dangerous Drugs were also invited to attend. As a result of these meetings, Ethical Guidelines were prepared for distribution to all physicians, in an attempt to curb the improper or indiscriminate treatment of addicts in offices of private physicians. The matter is still under study and final recommendations have not been made.

The *Maryland State Medical Journal* now carries a column in selected issues devoted to a particular ethical problem. A booklet is being prepared which will outline ethical rulings and policies of the Faculty, and which will be distributed to all members. In addition, a pamphlet describing the Commission on Medical Discipline, and explaining it in considerable detail, has been published and will be distributed to members.

As a result of publicity concerning weight control practices by certain physicians in Maryland, the Attorney General held a two-day public hearing on this subject. Members of the public, as well as certain physicians, other representatives of the health field, and AMA were invited to appear at these hearings. As a result, certain recommendations were made. One recommendation was in the field of physician education, and this is being carried out through the efforts of Faculty committees.

A Subcommittee of the Mediation Committee and Blue Shield was formed, at the request of Blue Shield, for the purpose of establishing liaison between Blue Shield and the Faculty with regard to various phases of utilization review. The committee held two meetings, the first, to establish guidelines for committee activities, and the second, to consider possible over-utilization and charging practices of one particular physician.

A Subcommittee to Study the Effect of Maryland's Abortion Law was also formed when reports were received that Maryland was becoming an "abortion mill". Questionnaires were distributed to all hospitals in the state, requesting information as to the number of abortions performed, and the reasons for them. To date, the returns have not been analyzed, but the committee remains active.

Guidelines for the handling of grievance cases were approved and distributed to all component societies. These were developed because of the increasing misunderstandings and difficulties involved in the proper and adequate handling of complaints filed by the public against physicians.

The Mediation Committee was charged with the responsibility of making determinations in variations from the standard telephone listings in the yellow pages of the telephone directories throughout the state. The Council adopted specific policies in this respect in 1967, and delegated to this committee the responsibility for determining what variations should be permitted in this area. The committee has approved certain minor variations for physicians in several counties throughout the state, all with component society approval or consent.

The Board of Medical Examiners has agreed, after suggestions from this committee, to prepare questions dealing with ethics on which physicians taking the licensure examination will be quizzed. Each time an application for the licensure examination is distributed, a copy of the Principles of Medical Ethics of the AMA will also be handed the examinee. We hope this is a step toward the education of the new physician in ethical matters. All too often, such individuals follow practices of other physicians who may be misinformed, and frequently they accept advice from finan-

cial or business management groups which are not familiar with medical ethics.

On the recommendation of the Mediation Committee, the Faculty's Council adopted the principle that direct telephone lines between a physician and a pharmacist are unethical. The Maryland Pharmaceutical Association has adopted the same ruling.

During the year, the Mediation Committee recommended that the membership of a physician be suspended because of an unethical act which the committee felt warranted such strong action. The Executive Committee concurred in this recommendation of the Mediation Committee, and took appropriate action.

The committee has noticed an increase in the number of problems coming before it. Many of these involve hospital emergency room cases and, in some instances, based upon the information before it, the committee feels these cases are handled very poorly by the hospitals concerned. It may be that some persons would wonder why physicians should be concerned over the poor policies in handling complaints that some hospitals seem to practice. Unfortunately, the public is of the opinion that physicians are responsible for hospital operations and, consequently, place the blame for inept handling of complaints at the physicians' door. The committee is still discussing this problem and, hopefully, can make some recommendations to appropriate parties in this regard.

Respectfully submitted,
LEWIS P. GUNDRY, MD, *Chairman*
KATHERINE H. BORKOVICH, MD
JOHN T. CHISSELL, MD
JOHN M. DENNIS, MD
ROBERT B. GOLDSTEIN, MD
LOUIS J. KOLODNER, MD
HENRY C. MELLETTE, MD
CHARLES F. O'DONNELL, MD
HILARY T. O'HERLIHY, MD
J. MORRIS REESE, MD
WILLIAM J. SULLIVAN, MD
HENRY C. WELCOME, MD

	Mediation Cases 1969 Total	Cases for Complainant	Cases for Defendant	Cases Pending at 12/31/68	Cases Settled Mutually	No Action Required	Referred to Bd. of Med. Examiners	Reprimanded
Allegany County	3				3			
Anne Arundel County	5			1	4			
Baltimore City	83	3	33	4	34	6	(3 to Med-Chi)	
Baltimore County	9		4		5			
Calvert County	0							
Caroline County	0							
Carroll County	1				1			
Cecil County	0							
Charles County	0							
Dorchester County								
Frederick County	0							
Garrett County	0							
Harford County	0							
Howard County	0							
Kent County	0							
Montgomery County*	36		12	13	11			
Prince George's County	25	1	16	1	7			
Queen Anne's County	0							
St. Mary's County	0							
Somerset County	0							
Talbot County	0							
Washington County	4	1	1	1	1			
Wicomico County	0							
Worcester County	0							
CASES HANDLED ON STATE LEVEL	46	10	8	2	5	5	12	4**

* 13 fee disputes for Blue Shield
** Included in Cases for Complainant

MEDICAL ADVISORY COMMITTEE OF THE AMERICAN RED CROSS BLOOD BANK PROGRAM

Mr. President and Members of the House of Delegates:

During the fiscal year of 1967-68, the American Red Cross collected 3,008,400 units of blood—an increase of 29,300 over last year's collection.

Whole blood was distributed to 4,300 hospitals in 48 states, the District of Columbia, Puerto Rico and the Virgin Islands. Two thousand five hundred of these hospitals received their total supply of blood from the American Red Cross.

In addition to whole blood, the following blood products were distributed:

Serum Albumin	**89,400 units (100 ml 25%)**
Gamma Globulin	**653,200 units (1 ml)**
Fibrinogen	**4,400 units (2 g)**
Vaccinia Immune Globulin	**1,900 units (5 ml)**
Packed Red Cells	**147,700 units (275 ml)**
Fresh Frozen Plasma	**59,500 units (225 ml)**
Platelet Rich Plasma	**1,400 units (225 ml)**
Platelet Concentrate	**20,500 units (25 ml)**
Cryoprecipitate	**21,100 units (20 ml)**
Antihemophilic Factor Concentrate	**2,600 vials**

The gross cost of all blood services by the national organization and chapters throughout the states was $34,509,100.

Respectfully submitted,
EVERETT S. DIGGS, MD
C. THOMAS FLOTTE, MD
GERALD A. GALVIN, MD
CARROLL L. SPURLING, MD
ARTHUR G. SIWINSKI, MD

MEDICAL ECONOMICS COMMITTEE

Mr. President and Members of the House of Delegates:

This committee held four meetings during the year. One meeting was devoted to an in-depth discussion of the Professional Liability Insurance program offered the members by the St. Paul Companies. The Company provided the committee with extensive information on premium income, expenses, as well as payment of claims and those amounts held in reserve for possible future claim payment. Unfortunately, it was necessary to recommend certain adjustments in the premiums offered to our members and such a suggestion was made to the Council. The Council approved this recommendation and the changes went into effect with all policy renewals and new policies written after approximately February 1, 1969.

During the past year, the committee provided malpractice panels to discuss common causes of malpractice action, to the various hospital staffs throughout the state. A total of five presentations were made. It was also brought to the attention of the St. Paul Company that the Faculty's panel considerations in pending malpractice actions were available to Maryland physicians in the Washington, D.C., area. It has been learned that many of the physicians in this area, as well as the St. Paul Company agents, were not aware of the existence of this Faculty service.

The other meetings were devoted to an examination of fees charged under Major Medical Insurance programs offered through insurance carriers. A total of fifteen cases was considered by the committee. Adjustments downward were made, insofar as the Usual, Customary, and Reasonable fee for similar procedures in the same community is concerned, in eight cases. The other cases, totalling seven, were determined to be within the range of Usual, Customary, and Reasonable fees. It is emphasized that no action is taken to determine an individual physician's fee. Rather, the committee in its response to the carriers, emphasizes that the physician has the right to charge what he determines his skill, time and effort are worth and that this is a valid contract between the physician and the patient. It is felt, however, that this service provided to carriers helps considerably in presenting the image of peer review so important today.

Respectfully submitted,
W. KENNETH MANSFIELD, MD, *Chairman*
FRED N. COLE, JR., MD
THOMAS CRAWFORD, MD
ALFRED S. NORTON, MD
FRANK M. SHIPLEY, MD
THOMAS K. MAHAN, MD
SAMUEL H. BRYANT, DDS

MEDICOLEGAL COMMITTEE

Mr. President and Members of the House of Delegates:

The committee held one meeting this year, but the three subcommittees met more frequently.

The Subcommittee on Interprofessional Relations has had four meetings, at which differences between physicians and attorneys have been settled. Most of these differences have centered around fees for expert witness testimony or deposition. There are differences of opinion as to what constitutes an "expert opinion" and whether fee for such testimony can be advanced by the attorney. It was agreed, finally, that fee for expert witness testimony, either in person or by deposition, is a legitimate item of expense which can be advanced by the attorney, but is reimbursable by the client. It is the duty of the attorney to see that the physician is paid his fee, although the attorney may not pay the fee from his own resources. It was also agreed that it is up to the attorney to discuss with the physician, at the time he requests his testimony, details of payment of such fee.

An amendment to the Medicolegal Code of Cooperation was approved by the committee, and considered by the Maryland State Bar Association at its midwinter meeting. However, some questions were raised by the Board of Governors and approval has been withheld pending further study.

An authorization and assignment form letter was designed which would give authorization to the physician to forward a medical report to the attorney representing his patient, and assignment of payment for professional services from proceeds of recovery. This will be submitted to the full committee for approval, and dissemination to physicians and attorneys.

Three cases were referred to the Grievance Committee of the Bar Association for consideration be-

cause of failure of attorneys to respond to correspondence from this committee.

The Symposium Subcommittee has done an excellent job this year, presenting two symposia. One was presented by physicians for attorneys at their mid-winter meeting, and the other by attorneys for physicians at the Faculty's Annual Meeting. The second symposium was a continuing dialogue on the subject of the Legal Effect of Malpractice Suits on the Practice of Medicine. Attendance at both symposia was excellent and the presentations were exceedingly well done. A full-page article was carried in the AMA NEWS regarding the first symposium.

The Subcommittee on Court Procedures met once, to reconsider the matter of a medicolegal screening panel, to evaluate malpractice actions against physicians and decide on their merit. This concept was rejected by the 1968 committee, but the new committee was asked to re-evaluate the problem. No new conclusions could be reached, but additional information was requested from California where an "arbitration" type program is being tried.

A representative of the Faculty attended the National Medicolegal Symposium in Las Vegas, Nevada, March 13-15, 1969.

Respectfully submitted,

ROBERT W. JOHNSON, III, MD, *Chairman*
CONRAD ACTON, MD
CLINTON R. HARRISON, MD
RUDIGER BREITENECKER, MD
JAMES D. DRINKARD, MD
PAUL E. HUFFINGTON, JR., MD
HOWARD F. KINNAMON, MD
J. ELLIOT LEVI, MD
B. MARTIN MIDDLETON, MD
BELDEN R. REAP, MD
JOHN F. STRAHAN, MD

NOMINATING COMMITTEE

Medical and Chirurgical Faculty
Nominations for 1970

Mr. President and Members of the House of Delegates:

(Those elected will assume office at conclusion of the Annual Meeting 1970, unless otherwise indicated.)

President-elect

HENRY A. BRIELE, Salisbury { President-Elect 1969-70 / President 1970-71

First Vice-President

JOHN F. SCHAEFER, Baltimore

Second Vice-President

CHARLES H. LIGON, Sandy Spring

Third Vice-President

DANIEL I. WELLIVER, Westminster

Secretary

WILLIAM A. PILLSBURY, Timonium

Treasurer

KARL F. MECH, Baltimore

Councilors

ROBERT B. GOLDSTEIN, Baltimore, Central District (1973)
HENRY P. LAUGHLIN, Bethesda, South Central (1973)
D. FRANK KALTREIDER, Baltimore, Central (1973)
JOHN C. HARVEY, Baltimore, Central (1973)
ARTHUR T. KEEFE, JR., Chestertown, Eastern (1973)
WILLIAM G. SPEED, III, Baltimore, Central (1973)
PHILIP F. WAGLEY, Baltimore, Central (1973)

Delegate to American Medical Association

RUSSELL S. FISHER, Baltimore
(Jan. 1, 1970—Dec. 31, 1972)

Alternate Delegate to American Medical Association

M. MCKENDREE BOYER, Damascus
(Jan. 1, 1970—Dec. 31, 1972)

Committee on Program and Arrangements

JULIUS R. KREVANS, Baltimore (1974)

Library and History Committee

PAUL F. GUERIN, Baltimore (1975)

Finney Fund Committee

THOMAS G. EDISON, Silver Spring (1975)

Board of Medical Examiners

J. ROY GUYTHER, Mechanicsville (June 1969—June 1971)
JOHN E. ADAMS, Towson (June 1969—June 1973)
DEWITT E. DELAWTER, Bethesda (June 1969—June 1973)

Respectfully submitted,

RICHARD D. BAUER, *Chairman,* Adelphi
OSCAR S. GULBRANDSEN, Eastern District, Chestertown
SAMUEL BORSSUCK, Southern District, Annapolis
WILLIAM L. STEWART, Western District, Westminster
THOMAS M. WILSON, South Central District, Bethesda
LOUIS J. KOLODNER, Central District, Baltimore
EMMANUEL A. SCHIMUNEK, At Large, Baltimore

OCCUPATIONAL HEALTH COMMITTEE

Mr. President and Members of the House of Delegates:

The Occupational Health Committee held one meeting this year. This was a dinner meeting to which each member brought one or two guests who are interested in occupational or industrial health. The guest speaker was Lomax Wells, MD, immediate past-chairman of AMA's Committee on Occupational Health. He spoke on federal legislation, and general matters pertaining to this health field.

Because of correspondence from a physician, the issue of Hong Kong flu immunizations being given at certain industrial plants was raised. Since it is believed that these were administered according to guidelines set by the Surgeon General, no action was taken.

Again, the issue of State Health Department laboratories being used for private patients was discussed. The medical director of the Maryland National Bank was contacted for information regarding the bank's

policy, but as of this writing, no reply has been received.

State legislation concerning occupational health was reviewed. Two bills, favored by this committee, were enacted by the Legislature. Two others, considered unfavorable, were killed in committee.

The committee was reminded that a candidate must be selected early for the Governor's Award to a Physician for Employment of the Handicapped.

Respectfully submitted,

HAROLD P. BIEHL, MD, *Chairman*
LAURA N. BAERNSTEIN, MD
GARY WALKER CAGE, MD
JOHN R. DAVIS, MD
WALTER E. FLEISCHER, MD
DONALD J. ROOP, MD
WILLIAM H. WALLOP, MD

PROFESSIONAL MEDICAL SERVICES COMMITTEE

Mr. President and Members of the House of Delegates:

During the past year, considerable time has been devoted to a discussion of whether the *Fee Guide,* published in 1966, should be updated, or whether the committee should continue to take the position that the concept of Usual, Customary, and Reasonable fees should prevail. Inasmuch as the House of Delegates has adopted this latter position, no formal action has been taken by the committee. It will, in all probability, continue to discuss this concept and, if necessary, make appropriate recommendations in this regard.

Liaison has continued with the State Health Department, through the Special Liaison Committee to Meet With State Health Department Representatives. This committee was disbanded in January 1969, and its functions assumed by the Faculty's Executive Committee. In this area, close contact was maintained with the State Health Department in preparation of its 1970 fiscal year budget requests.

The committee also received status reports with respect to replacement of the present Workmen's Compensation Commission Fee Guide with the concept of Usual, Customary, and Reasonable fees. The House of Delegates adopted Resolution 1S/68 dealing with this subject at its Annual Meeting, April 11, 1969, thus closing out this aspect of the committee's activity at this time.

During the year, the Executive Secretary was requested to prepare a report dealing with the delivery of health care services. This was completed, and An Analyses of Health Care Services in Maryland was presented to the committee for consideration at its January 29, 1969, meeting. A general discussion ensued regarding the various methods available for delivery of health care services to disadvantaged persons, particularly in the urban areas of Maryland. No conclusions in this regard were reached.

In December 1968, the committee was asked to meet with Maryland Medical Service (Blue Shield) to discuss a proposal to have that organization assume the responsibility for the state's Medicaid program. Since that time, the Council has assumed direction of any discussions with state officials in this regard. The committee has gone on record as being in favor of the proposal for a Multiphasic Screening Program being studied by a special ad hoc committee formed for this purpose.

GEORGE H. GREENSTEIN, MD, *Chairman*
WORTH B. DANIELS, JR., MD
A. GIBSON PACKARD, MD
ALBERT J. WEISS, MD
HARRY B. RANDALL, MD
WATSON KIME, MD
JOHN F. HOGAN, JR., MD
JOHN E. MILLER, MD
THEODORE E. STACY, JR., MD
LEX B. SMITH, MD
MORRIS J. WIZENBERG, MD
ISRAEL ZELIGMAN, MD
H. BERTON MCCAULEY, DDS
HOWARD N. WEEKS, MD
WILLARD F. SMITH, MD
ALBERTA A. POLIN, MD
BENJAMIN S. MILLER, MD
EMMANUEL A. SCHIMUNEK, MD
WILLIAM A. MOSBERG, JR., MD
ROBERT W. JOHNSON, III, MD
ROBERT T. THIBADEAU, MD
WILLIAM A. TYSON, MD
EDWIN H. STEWART, JR., MD
PIERSON M. CHECKET, MD
OSBORNE D. CHRISTENSEN, MD
ARCHIE R. COHEN, MD
JOHN R. DAVIS, MD
NEVILLE A. BARON, MD
MR. CHAD COMBS

REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

The Reference Committee met on Thursday, March 20, 1969, to discuss the various resolutions before it. Each Faculty member was notified of the hearing by a postal card mailed to them on March 5, 1969. In addition, all Delegates, Alternate Delegates, Officers of Component Societies and others were sent copies of the resolutions under date of March 3, 1969.

Resolution 1 S/68

Submitted on: July 5, 1969

Introduced by: Marion Friedman, MD, and 31 other members of the Baltimore City Medical Society

Subject: Workmen's Compensation Cases being charged on the basis of "Usual, Customary and Reasonable Fees"; and suggesting a course of action in this regard.

Whereas, The United States Government through its various health programs such as Medicare (Title 18), the Federal Employees Health Insurance Program, and U.S. Armed Forces Dependents Medical Care

Program, as well as many others, is based on the concept of payment to the physician of his Usual and Customary Fee; and

Whereas, The United Steel Workers of America has negotiated contracts with their employers that provide for provision of health insurance making payment to physicians on the basis of their Usual and Customary Fees; and

Whereas, The House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland on September 9, 1966, adopted a resolution in which the "resolved" portion reads as follows:

Resolved, That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland go on record as urging its members to submit bills for payment of "usual, customary and reasonable fees" for professional services rendered Workmen's Compensation Cases, as well as other Governmental agencies; and

Whereas, The present provisions of the Workmen's Compensation Law, Article 101, Section 37 (c) reads as follows:

> "All fees and other charges for such treatment and services shall be subject to regulation by the Commission, and shall be *limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living,"* and

(emphasis ours)

Whereas, The Workmen's Compensation Commission has authorized hospitals providing services to persons covered under the Workmen's Compensation Laws of this State to bill at their "posted charges," without having to request a hearing and without obtaining permission for any such increases in charges; and

Whereas, Under present regulations of the Workmen's Compensation Commission the individual physician is forced to request arbitration of fees by the Commission when Insurance Carriers elect not to pay the physician's Usual and Customary fees, but abide rigidly to the Fee *Guide* published by the Workmen's Compensation Commission; and

Whereas, Within the Medical and Chirurgical Faculty's organization are reliable mechanisms through which questionable fees charged by physicians may be adjudicated; and

Whereas, At least ten other states already work under the concept of Usual, Customary and Reasonable fees for physicians' services in their handling of Workmen's Compensation cases; and

Whereas, There is no reason why Workmen's Compensation Recipients should be treated differently from other patients of physicians; and

Whereas, This disparity in treatment by Insurance Carriers and the Commission could lead to substandard medical treatment of Workmen's Compensation Cases; now therefore, be it

Deletion Recommended

Resolved, That Physicians in Maryland be urged to advise all insurance carriers that they intend to charge their Usual, Customary and Reasonable fees for Workmen's Compensation cases seen by them; and be it further

Resolved, That Insurance Carriers who continue to arbitrarily reduce fees paid to physicians for such Workmen's Compensation cases be taken to court so that a test case can be made to determine if they are in violation of the law as it is presently written; and be it further

Resolved, That physicians who elect not to see such Workmen's Compensation Cases because of this arbitrary attitude on the part of the groups involved so notify the Insurance Carriers, requesting them to seek the services of other physicians for care of such patients.

Since the September, 1968, Semiannual Meeting, an informal meeting was held with the entire membership of the Workmen's Compensation Commission. Following that meeting, a communication, dated January 22, 1969, was received from the Commission which reads, in part, as follows:

> "You are hereby advised that the Commission has rejected the request of the Faculty for a fee schedule based on the usual, customary and reasonable fees. Under the law, as soon as a fee schedule has been revised (on which some work is now being done), it will be published as required and a hearing scheduled."

The Faculty's House of Delegates has repeatedly stated that it supports the concept of payment of Usual, Customary and Reasonable Fees for all payments made by third parties. If a fee schedule is adopted by the Workmen's Compensation Commission it is the responsibility of each physician to determine for himself if the schedule falls within his *personal Usual, Customary and Reasonable fee.* If he wishes to continue to treat Workmen's Compensation cases, he can do so with that understanding.

If physicians, individually or collectively, wish to submit a guide to the Workmen's Compensation Commission as their usual and customary fees, this would not be in conflict with Faculty policy.

There are, doubtless, many others whose fees will probably be higher or lower than the schedule the Commission may finally adopt. If this is the case, the Resolveds of Resolution 1S/68 can come into operation.

In adopting this resolution, it is understood that the Faculty takes the position that the wording contained in the current Annotated Code of Maryland and cited in the Resolution as being Article 101, Section 37 (c), provides for payment of Usual, Customary and Reasonable Fees. It is also understood that the Faculty will instigate the court case to determine if the Commission is, indeed, in violation of the law.

In this light, the Reference Committee recommends to the House of Delegates that Resolution 1S/68 be amended by striking out the last paragraph of the preamble and that, as amended, the Resolution be adopted.

Resolution 1A/69

Submitted on: September 19, 1968

Introduced by: Prince Georges Medical Association

Subject: Formation of a Committee to Formulate Model Group Hospital and Medical Insurance Master Policies; and Make its Services Available to Interested Persons; and Urge the AMA to Establish a Similar Committee

Whereas, We as physicians have noted a tremendous increase in the number and type of the various group health insurance programs; and

Whereas, We believe these programs, if properly handled, can be of great benefit to both employers and employees, as well as the general public; and

Whereas, There is a current tendency on the part of some insurance companies to reduce policy benefits in order to sell substandard policies at lower prices to employers who are not aware of the facts and who lack the requisite expertise to compare and evaluate competing plans; and

Whereas, Physicians through their national, state and county medical societies are in a unique position to advise and counsel with employers, employees, insurance companies and the general public in health insurance matters; now, therefore, be it

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland* establish a committee whose purpose it shall be to formulate model group hospital and medical insurance master policies for use by employees, employers, insurance companies and members of the general public in this State; and

Resolved, That said committee shall thereafter furnish consultation services to interested persons, firms or groups with respect to such insurance programs so that each party to such transactions can be made fully aware of the essential elements of proposed insurance plans in order that they may intelligently evaluate and compare the same; and

Resolved, That the Medical and Chirurgical Faculty of the State of Maryland urge the American Medical Association to establish a similar committee for the same purpose on a national basis.

NOTE: See Art. XI, Section 3 (Economics Committee) and Section 16 (Occupational Health) for possible crossing of lines of interest.

** The word "standing" has been stricken since the bylaws would require amendment to create such a committee and if "standing" is insisted on, the resolution is not in order.*

This resolution provides for a committee of the Faculty to become knowledgeable and give advice in connection with "model group hospital and medical insurance master policies." This is a problem with which the American Medical Association has been struggling for some years. The AMA has determined recently that it is impossible to define minimum standards applicable to all. The AMA has, however, attacked the problem by providing factual information for those who wish it, in connection with what buyers of health care insurance should look for and be aware of. This factual data, it is anticipated, will be forthcoming shortly and be available to all those who wish to have such information. Your Reference Committee believes this resolution to have considerable merit and recommends that the final Resolved be stricken, inasmuch as its intent has already been accomplished on a national level, and that Resolution 1A/69 be adopted, as amended.

Resolution 2A/69

Submitted on: February 13, 1969

Introduced by: William G. Esmond, MD, and 37 other members of the Baltimore City Medical Society

Subject: Authentication of house staff examinations by attending or operating physicians prior to major medical or surgical procedures being performed

Whereas, The Joint Commission on Accreditation of Hospitals specifies that:

". . . the Joint Commission on Accreditation of Hospitals reaffirms its conviction that history-taking and physical examination of a patient admitted to a hospital are a part of the practice of medicine; their unsupervised performance and unreviewed recording by medical students are not conducive to the best quality of medical care, are not a useful learning experience, and may place the extern, the attending physician, and the hosiptal in legal jeopardy. They cannot therefore be considered acceptable practices in an accredited hospital, as either an economic resource for students or a time-saving device for physicians."

and,

Whereas, It is obvious from such a statement that any patient who is scheduled for surgical procedures or who is in need of a medical regime that requires the skills of a licensed physician should have such history and physical examination authenticated by the attending physician or a qualified individual (by that is meant a licensed physician); and,

Whereas, It has become known that this is not always the practice that is being followed in some hospitals that utilize the services of externs; and

Whereas, Such practices cannot be condoned under any circumstances; be it, therefore,

Resolved, That the Medical and Chirurgical Faculty

of the State of Maryland, in the interest of better patient care, requires that BEFORE SURGICAL PROCEDURES ARE PERFORMED AND BEFORE MEDICAL REGIMES OR TREATMENT ARE ESTABLISHED, that histories and physicals performed by externs or house staff, be properly authenticated and approved by a legally licensed physician.

The Joint Commission on Accreditation of Hospitals has already established appropriate criteria pertinent to this problem. It is believed that implementation and/or modification of the JCAH criteria lies in the province of the Medical Staff of individual hospitals, rather than the Medical and Chirurgical Faculty.

In light of certain emergency situations which could arise, attempts by the Faculty to specify which house officers should countersign physical examinations, and when, could interfere with or delay prompt and adequate care of patients.

Your Reference Committee recommends, therefore, that Resolution 2A/69 NOT be adopted.

Resolution 3A/69

Submitted on: February 14, 1969

Introduced by: Washington County Medical Society

Subject: Directing that Local Component Medical Societies Establish Policies on a Local Level for Yellow Page Telephone Directory Listings.

Whereas, The American Medical Association has sent guidelines to the Medical and Chirurgical Faculty dealing with telephone listings of physicians; which included a statement that control should be at the local society level; and

Whereas, The Medical and Chirurgical Faculty Council (11-16-67) has taken action to enforce its own interpretations of these guidelines without placing control at the local society level; and

Whereas, The enforced terminology "practice limited to" without further explanation has been misinterpreted by patients, in some localities, that certain doctors no longer practice subspecialties; therefore, be it

Resolved, That telephone listings should be made in accordance with guidelines established by the local component societies which will consider, but not necessarily rigidly adhere to the guidelines established by the American Medical Association as interpreted by the Council of the Medical and Chirurgical Faculty; and be it further

Resolved, That a copy of this resolution be forwarded to the C & P Telephone Company and to the Reuben H. Donnelly Telephone Directory Company.

This resolution was considered in the light of the policies adopted by the Faculty's Council on November 16, 1967, which includes the following statement:

"Listings may be made *only* as follows:

Practice limited to..... (Using only those specialties being approved by the American Medical Association or as modified and approved by a special liaison group* to be named by the Faculty to work with the C & P Telephone Company)"

* Mediation Committee

It is obvious that exceptions to the rules adopted by the Council can be made. An appropriate Faculty Committee has been charged with this responsibility and indeed carefully evaluates each request for variation that occurs. Exceptions have been approved for individuals in Washington County, as well as Baltimore City, Baltimore County, Carroll County, Allegany County and others.

Your Reference Committee is of the opinion that adequate mechanisms exist for making exceptions to the rulings. It also is of the opinion that the C & P Telephone Company and the Reuben H. Donnelly Corporation both need to have some consistency in the policy that is followed throughout the State. This is particularly true where more than one county is included in the local telephone directory. The Reference Committee believes that the Council acted in a proper manner and within its authority in adopting this policy on November 16, 1967. Your Reference Committee, therefore, recommends that Resolution 3A/69 *NOT* be adopted.

In closing, your Reference Committee would like to bring to the attention of the House of Delegates that, frequently, resolutions are introduced for which policies already exist. It urges each member of the House of Delegates to convey to their component society the fact that material contained or being considered for resolutions be thoroughly investigated before introduction of resolutions that may well be unnecessary. By doing this, the time of the Committees, Delegates, Council members, Officers and Staff—as well as considerable expense —would be saved.

The Reference Committee does not wish to "gag" any group of individuals or any component society but hopes that serious consideration will be given these suggestions.

The Reference Committee wishes to express its appreciation to the Faculty staff who have so ably researched and assisted in its deliberations.

Respectfully submitted,

HERBERT H. LEIGHTON, MD, Oakland, *Chairman*
DEWITT E. DELAWTER, MD, Bethesda
WILLIAM H. MOSBERG, MD, Baltimore
EMMANUEL A. SCHIMUNEK, MD, Baltimore
RAYMOND M. YOW, MD, Salisbury

your medical faculty at work

by John Sargeant
Executive Secretary

The Faculty's Annual Meeting of the House of Delegates took place on April 9 and 11 and proceeded as follows:

1. Adopted minutes of the semiannual sessions, September 5 and 6, 1968;
2. Observed a moment's silence in memory of deceased members;
3. Adopted a resolution honoring the memory of Wetherbee Fort, MD;
4. Adopted a resolution honoring William S. Stone, MD, on the occasion of his retirement as Dean of the University of Maryland School of Medicine;
5. Awarded Viet Nam plaques to those members who have served on voluntary duty in Viet Nam;
6. Presented Fifty-year pins to those members who have completed this tenure of Faculty membership;
7. Elected certain members to Emeritus Membership and one member to Honorary Membership;
8. Disbanded the PL 89-97 Liaison Subcommittee, on recommendation of the Council;
9. Adopted a resolution appropriating sufficient funds to continue the MEDIC Network for the coming MEDIC year;
10. Presented Dean Stone with a plaque honoring his retirement;
11. Presented AMAERF checks to The John Hopkins University School of Medicine in the amount of $8,737.11; and the University of Maryland School of Medicine in the amount of $13,550.53;
12. Referred a recommendation to the Policy and Planning Committee for clarification, along with a pending amendment to the recommendation;
13. Adopted various bylaws amendments; and referred one proposed amendment to the Bylaw Committee for further study and report;
14. Elected officers for the 1970-1971 Faculty year;
15. Presented a scroll honoring his 53 years of service to the community to J. G. F. Smith, MD, of Brunswick, Md.;
16. Heard reports from the Presidents of the Woman's Auxiliary, Student American Medical Association, and the Maryland Medical Political Action Committee;
17. Adopted as amended a resolution that urges physicians to charge their Usual, Customary, and Reasonable fees for cases treated under Workmen's Compensation; and authorized legal action for a test case to determine if there is a violation of the law as it is presently written if carriers refuse to make payment on this basis;
18. Adopted as amended a resolution dealing with referral to a standing committee a proposal for formulating model group hospital and medical insurance master policies for use by employees, employers, insurance companies, and the general public;
19. Rejected a resolution dealing with the requirement that histories and physicals performed by house staff be properly authenticated and approved by a legally licensed physician on the grounds that this responsibility rested with Joint Commission on Accreditation of Hospitals;
20. Rejected a resolution that would have delegated to local component societies the determination for telephone directory yellow page listings of physicians on the basis that many directories crossed county lines; and that there needs to be uniformity throughout the state in this regard;
21. Offered the Governor any "advice, information or consultation" in connection with the appointment of a Secretary of Health and Mental Hygiene;
22. Defeated a proposed bylaw amendment offered by the Baltimore City Delegation that would have required the House to elect those Council members the Components selected for that purpose.



A Service of the Tuberculosis Association of Maryland

tuberculosis

Tuberculin Testing Program

Tuberculin tests using the standard Mantoux technique, will be offered to all persons over 15 years of age, reporting to the Maryland Tuberculosis Association Screening Center for chest X-rays. It is proposed that this program will go into effect on or about June 15, 1969. It will be considered as a demonstration aimed at determining what portion of the approximately 25,000 apparently healthy individuals reporting to the center annually react positively to the standard tuberculin test.

The Screening Center will be staffed by a registered nurse, two technicians, and one clerk-typist. The nurse will be charged with the responsibility of operating the center under the administrative supervision of the executive director of the Maryland Tuberculosis Association. A licensed physician will be in charge of the medical aspects of the program, eg, reading the X-ray films, interpreting the tuberculin test results. The registered nurse will administer the tests and measure the results for interpretation by the physician in charge. Referring physicians may elect to interpret the test results themselves. However, if they do not choose to do this, the tests will be read by the association physician.* The test will consist of the intracutaneous injection by the Mantoux technique of 0.0001 mg of standardized PPD tuberculin. This is the intermediate dose, equivalent to five tuberculin units.

The total program and policies to be followed will be constantly evaluated by a special committee appointed by the presidents of the Maryland Tuberculosis Association, Incorporated, and the Maryland Thoracic Society, with representation from the Baltimore City Health Department, the Maryland State Department of Health, and the state and city medical societies. This committee will meet regularly to evaluate and study both procedures and results.

Official support and sanction is being asked from the official agencies and medical groups represented on the committee.

An intensive education and promotional program was conducted during the months of April and May in order that all physicians, practicing in Baltimore, could be fully advised as to the program, its purposes, and its procedures.

Advice and consultation to physicians as to the handling of positive reactors will be offered to all physicians by a selected panel chosen from members of the Maryland Thoracic Society. This is believed necessary as individuals who are determined to have a positive reaction will be referred, either to a physician of their choice or to the appropriate health department for supervision.

Wide community publicity will be given so that the entire Baltimore community will be aware of the expansion of the association's case-detection program and the reasons for this expansion. Emphasis will be made of the fact that most active tuberculosis develops among positive tuberculin reactors.

The association will establish a procedure of follow-up as to final disposition of each person whose test is positive and who has been referred, with suggested chemoprophylaxis either to a health department or to a private physician. This will afford a method by which the success or failure of the program can be properly measured. In addition, thought will be given to establishing a tuberculin reactor register which will assist in determining the success of the referral and follow-up program.

All costs of the program, with the exception of the tuberculin, will be borne by the Maryland Tuberculosis Association. The Baltimore City Health De-

** Test results will be reported to the referring physician.*

partment will furnish the tuberculin without charge.

Appropriate, medically approved, educational, and promotional literature will be developed by the association for distribution to the practicing physician and the general public.

This program is being conducted as a pilot demonstration to determine the feasibility and effectiveness of offering a free tuberculin test to a cross-section of the community who would not normally report to the Mobile Chest X-ray unit or to a health department clinic for a chest X-ray.

Edmund G. Beacham, MD, Chairman
Director Tuberculosis Division, Baltimore City Hospitals

John E. Miller, MD
Past President Maryland Thoracic Society
Chairman, G. Canby Robinson Memorial Fund Committee of the Maryland Tuberculosis Association and Maryland Thoracic Society

Allan S. Moodie, MD
Administrative Tuberculosis Control Officer
Baltimore City Health Department

Milton B. Kress, MD
Member Maryland Thoracic Society
Chairman, Respiratory Disease Committee,
Maryland Tuberculosis Association

Mrs. Emily P. Hardy, PHN, Board Member
Maryland Tuberculosis Association

George W. Comstock, MD
Professor of Epidemiology, School of Hygiene and Public Health, The Johns Hopkins University
Consultant, Tuberculosis Program, United States Public Health Service

Baltimore City physicians interested in more information on the program call Frank T. Jones, Executive Director, Maryland Tuberculosis & Respiratory Disease Association, at 685-6484.

HIGHLAND HOSPITAL

Asheville, North Carolina
Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational aotivities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, *Coordinator of Admissions*

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—254-3201

HEALTH DEPARTMENT
CITY OF BALTIMORE
1797
BALTIMORE

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Mayor's Task Force on Nutrition

A coordinated effort, involving citizens, local, state, and federal agencies, directed toward alleviating the problem of malnutrition in Baltimore city was initiated on February 19.

The Mayor's "Task Force on Nutrition" is comprised of representatives from his office and the City Council, the Baltimore City Health Department, Baltimore City Public Schools, the Archdiocese of Baltimore, the City Department of Housing and Community Development, the Department of Agriculture (Baltimore office), the Baltimore City Department of Social Services, the Maryland State Department of Education, the Maryland State Department of Health, the State Department of Social Services, the Baltimore League of Women Voters, the Maryland Conference on Social Welfare (Child Welfare Division), the Faculty Wives' Club of The Johns Hopkins University, and the Maryland Committee for Day Care of Children.

Matthew Tayback, ScD, deputy commissioner of health of the City Health Department, is chairman of the Task Force. Regional consultants are John F. Conaboy, U.S. Department of Agriculture Regional Supervisor of Food Stamps Programs, and Miss Mary Brice Deaver, from the Children's Bureau Regional Office, Charlottesville, Va.

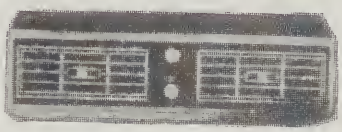
Some of the objectives of the Task Force include: a review of existing resources for food distribution and nutrition education, and their expansion and effective utilization; the formulation of guidelines to assist school principals in identifying children eligible for school food programs; support of the Department of Education's efforts to seek additional funds for free or reduced cost school lunches; the enforcement of federal and state legislation to expand and liberalize the school lunch and food stamp programs; and the upgrading of the nutrition status of preschool children, and the city's needy, through modification of Food Stamp and Social Services agency programs.

In seeking to attain these goals, the Mayor's Task Force is taking the initiative in a unique effort to meld agency projects into one coordinated program in order to deliver effectively the benefits of planned nutrition programs to the city's poor.

JOIN OUR TAPE CLUB
FREE! FREE!
One tape Free with every 10 tapes you buy at our everyday low prices. **25% DISCOUNT** on all tapes, by such artists as: **Beatles, Glen Campbell, Cream, Frank Sinatra, Al Martino, Dean Martin.**

20TH CENTURY AUTO RADIO & TV
912-922 CATHEDRAL ST. (at Eager)
BALTIMORE, MD. 21201
Phone 539-0662

20TH CENTURY
DRIVE-IN—FAST SERVICE



STEREO TAPE PLAYER
for CAR, BOAT or HOME



AUTO AIR CONDITIONERS
SALES and SERVICES

For elderly patients in need of a mild tranquilizer consider **Tybatran®**

brand of tybamate

(When you consult the Prescribing Information you may agree it makes good sense)



PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

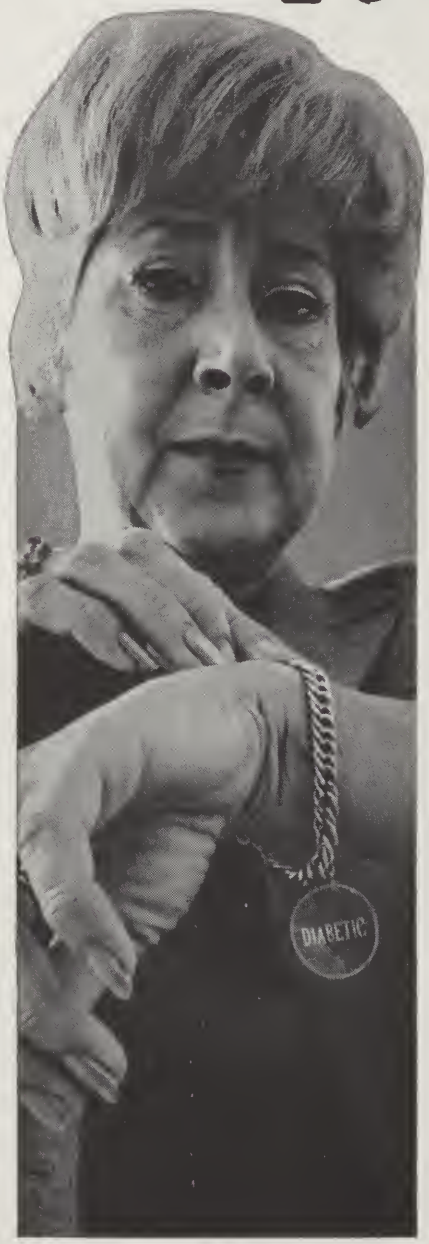
Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens... and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

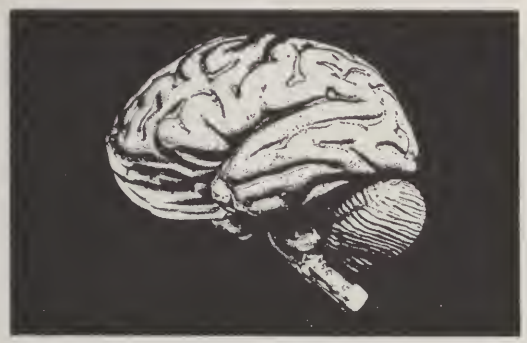
Tetrex-F®
(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5 —2/23/67. For complete information consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.
Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

On The Care of The Mentally Subnormal

Maryland currently requires 1,126 hospital beds for the retarded in addition to available capacity to meet the state's estimated minimum need. Although construction at Rosewood and the opening of Henryton has provided space for 770 patients since 1960, this has barely exceeded the increased need resulting from Maryland's burgeoning population. The average size of the patient population is now 16.6% above bed capacity, a slight reduction from the 20.3% noted in 1960.

FISCAL YEAR	BED CAPACITY*	AVERAGE SIZE OF PATIENT POPULATION	EXCESS PATIENTS	ESTIMATED BED NEED**	ADDITIONAL BEDS NEEDED
1960	1,873	2,254	381	3,017	1,144
1962	1,873	2,400	527	3,166	1,293
1964	2,073	2,616	543	3,353	1,280
1966	2,564	2,888	324	3,551	987
1968	2,624	3,089	465	3,692	1,068
1969 (est.)	2,643	3,085	442	3,769	1,126

*** Based on an average of 70 square feet of bed space.**
****One Bed for every 1,000 estimated total state residents as recommended by the American Association on Mental Deficiency.**

A new facility, now being built near Beltsville in the Washington metropolitan area, will have an initial capacity for 230 patients. Other planned and authorized construction at Rosewood, Beltsville, and in a number of smaller units in different sections of the state, will provide space for approximately 840 additional patients by 1972. However, since the minimum bed need is estimated to increase by then to 3,974, Maryland will still have a deficiency of at least 261 beds when the current building program is completed.

The above data provide one indication of the need for expanded support for mental retardation programs. Other available indices* show that Maryland, in comparison with other states, ranked 23 in average expenditure per patient, 30 on the number of beds per 1,000 total residents and 32 on the ratio of personnel to patients. On each of the above factors, Maryland was below the national average.

Since Maryland's total population is growing by approximately 65,000 people a year, it must be anticipated that the demand for inpatient services will similarly increase. The immediate need, therefore, is for continuing construction together with improved staffing ratios in present and future facilities. Longer range efforts must relate to (1) research and preventive programs for reducing the incidence of mental retardation; (2) increased training and educational programs for the retarded to permit maximum development of their potential; and (3) establishment and expansion of closely coordinated community centered services such as, day care centers, halfway houses, sheltered workshops, group care homes, small residential facilities, and other suitable substitutes for hospitalization.

* National Institute of Mental Health—Provisional Patient Movement and Administrative Data—Public Institutions For the Mentally Retarded, July 1, 1967-June 30, 1968.

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545

Achromycin V
250 mg. capsules

ACHROMYCIN® V
TETRACYCLINE HCl Lederle
4810-9

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

PROFESSIONAL LEASING
Special low rates for our medical customers. Call or stop in.

MONARCH

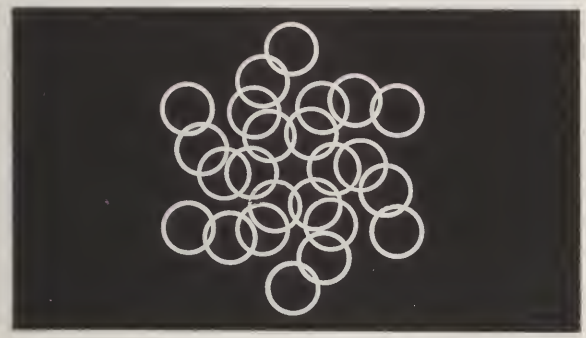
COUGAR MERCURY MONTEGO CONTINENTAL
5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

Savings

help you hurdle extra expenses. Make extra pleasures possible.

Dividends Paid Quarterly

Chesapeake Federal
SAVINGS & LOAN ASSOCIATION
2240 EASTERN AVE. Corner PATTERSON PARK
ORLEANS 5-6602



From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Medical Team Sketches Portrait of Alcoholic

Despite all the attention given to it, alcoholism remains a most perplexing medical problem. Though regarded by many as a disease entity, it has no characteristic course and no accepted way of management. Yet the physician is under increasing pressure from society—and medicine itself—to treat the alcoholic.

What should the doctor do for the alcoholic during the acute stages of intoxication and during the period of withdrawal? What associated illnesses or conditions should he look for? To help the doctor answer these questions, the Alcoholism and Drugs Addiction Research Foundation of Ontario set up a 32-bed research and treatment unit in the summer of 1967. By the fall of 1970, this unit will become the nucleus of the foundation's new 110-bed hospital on the University of Toronto campus for the study and treatment of patients who are dependent on drugs or alcohol.

So far, more than 1,000 patients have gone through the unit run by the foundation, which is an agency of the provincial government. The team, headed by Jack Olin, MD, the unit's medical director, has found the expected neglect, scars, telangiectasia, spider nevi, and hepatic enlargements. But they have also found a number of unexpected clinical signs.

A particularly common finding was *Candida albicans* infection in the mouths of alcoholics. The infection—far advanced in some cases—has shown up in almost 50% of the 500 alcoholics seen by Murray Cornish, DDS, a dentist who works as a consultant in the unit. By contrast, he has seen these fungal infections in only 1% of the patients in his private practice.

Dr. Cornish, who is head of oral diagnosis at Toronto's New Mount Sinai Hospital, has also observed hyperkeratinization in the gums of alcoholics —probably from the rubbing of ill-fitting dentures and gnashing of teeth. In addition, he has come across far advanced cases of papillary hyperplasia of the tongue, a condition he believes is frequently precancerous.

The relationship between oral lesions and neoplasms is a potentially fruitful area of medical research, says Dr. Cornish. He notes that last year in Ontario, which has a population of more than seven million, dentists found only five oral neoplasms among patients in their practices. The dental service at the alcoholic unit, on the other hand, has detected between 18 and 20 oral neoplasms. One of these tumors, a basal cell carcinoma of the lip, was apparently triggered by the repeated burning down of cigarettes while the patient was anesthetized by alcohol.

Perhaps the most surprising report to come out of the unit is: Very few alcoholics have cirrhosis. Medical director Olin notes that in less than 1% of their patients, who are usually referred by private practitioners, were the unit's doctors able to confirm a diagnosis of the liver disorder.

"The picture of alcoholism and cirrhosis is grossly distorted in general hospital statistics," charges Dr. Olin. He feels that the incidence of cirrhosis in even chronic abusers in the general population is no greater than 4%.

The diagnostic label of cirrhosis "is affixed to a large number of alcoholics who, in fact, have only a fatty liver," asserts Paul Devenyi, MD, senior physician at the unit. He notes that in a series of 100 randomly selected alcoholics—all of whom had been drinking steadily up to the time of admission—liver biopsies showed that two thirds of them had fatty livers. But only two turned out to have cirrhosis.

"Since the majority of alcoholics develop transient fatty liver, but only a few of these develop cirrhosis,

Reprinted by permission of *Medical World News*, © copyright 1969 McGraw-Hill, Inc.

we cannot say that fatty liver leads to cirrhosis," says Dr. Devenyi. "Something besides alcohol or nutritional deficiency is necessary for the development of cirrhosis—perhaps a constitutional or genetic predisposition that we do not understand as yet."

Nor do nutritional deficiencies seem to be responsible for fatty liver. The condition is found just as often among those alcoholics who do eat as among those who do not eat while drinking, reports Dr. Olin. "This finding tends to support the thesis that alcohol, acting as a direct toxin, is the important factor producing liver damage."

Another unexpected finding was that 10% of the chronic alcoholics were color-blind. This discovery partly supports earlier reports by a group in Chile. But though the Chileans found yellow-blue deficiencies, the Toronto group detected red-green deficiencies. Whether these patients will recover from their color blindness if they abstain from alcohol remains to be seen.

Treating the alcoholic patient poses special problems if the doctor, like those in the Toronto unit, sees him while he is suffering from acute intoxication or from acute withdrawal. But, even though the intoxicated patient may be irrational and violent, he is usually handled at the unit without the aid of sedatives and tranquilizers.

Since alcohol itself is a central nervous system depressant, giving the patient another CNS depressant while he is drunk may lead to unpredictable results—even death, says Dr. Devenyi. "We find that most intoxicated patients can be managed by avoiding argument and getting them gently to bed. Left alone, they will fall asleep without any medication. We meticulously avoid any CNS-depressing drugs in patients whose blood alcohol level exceeds 0.15%.

Theoretically, the patient would benefit from a drug that would speed up the metabolism of alcohol. A number of agents—including triiodothyronine, insulin, and glucose—have been tried. But Dr. Devenyi knows of nothing that can accelerate alcohol metabolism reliably.

"Although sedatives are avoided during acute intoxication, they are the key to effective management of the patient during the withdrawal stage," says the Toronto physician. At the alcoholic unit, benzodiazepines such as chlordiazepoxide (*Librium*) and diazepam (*Valium*) are preferred to the phenothiazines, which may cause a sudden drop in blood pressure and, in some cases, convulsions. Barbiturates are avoided in all phases of alcoholism treatment, notes Dr. Devenyi, because alcoholic patients also show a high incidence of barbiturate abuse.

He says chlordiazepoxide is given in fairly high doses—100 mg intramuscularly or sometimes intravenously—every hour or two for about 12 hours. Then the drug is administered orally, the dosage gradually being reduced to 50 mg and then 25 mg three or four times a day.

Room for 'Hair of the Dog'?

One of the most popular remedies for alcohol withdrawal symptoms—the one used most often by alcoholics—is alcohol itself. Dr. Devenyi does not hold with the theory that a hair of the dog that bit you is a good remedy. "It only serves to perpetuate the vicious round of drinking."

Once the medical doctor has dealt with the acute phases of alcoholism, other professionals must assume an increasing role in maintaining the patient's sobriety, says Dr. Devenyi. But, he says, the doctor should not step out of the picture completely. Medical care—judicious use of antidepressants and tranquilizers, administration of disulfiram (Antabuse)—may still be needed. "One should make an effort to see that the patient is not discharged with nowhere to go, but that he will get some sort of support, supervision, psychotherapy, or whatever he may need."

MANUEL SCHWARTZ
HEARING REHABILITATION
321 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201
DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION
Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

TOURS ARRANGED TO MEDICAL CONFERENCES AND CONCLAVES
Domestic and International
GLOBETROTTER TRAVEL
A Professional Travel Service
BALTIMORE: REISTERSTOWN ROAD PLAZA • 358-6444
BALTIMORE: MONDAWMIN SHOPPING CENTER • 669-8200
WASHINGTON: WHEATON PL. SHOPPING CTR. • 949-1700



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Osteoarthritis of the Hip

Arthritis Foundation Series
The Arthritis Foundation
(Maryland Chapter, 12 West 25th St., Balto., Md. 21218)
is arranging a series of articles by experts on arthritis to appear from time to time in Rehabilitation Notes.

NORTON I. GETTES, MD
Instructor in Orthopaedic Surgery
Johns Hopkins University

Osteoarthritis of the hip is a condition which usually develops when, for one reason or another, articular cartilage is caused to be worn away or destroyed on either the weight-bearing surface of the head of the femur or the acetabulum or both. The arthritis can develop as a result of a circulatory disturbance producing avascular necrosis of the head of the femur or from old sepsis, old trauma, or excessive "wear and tear." It can also result from a generalized joint disease process or from a congenital or developmental disorder, such as congenital dislocation of the hip, Legg-Perthes disease, or slipping of the capital femoral epiphysis. As a result of any of the foregoing disturbances, deformity in the joint develops. The usually congruous joint becomes incongruous. The deformity ultimately results in narrowing of the joint space, osteophyte formation, and superior and lateral subluxation of the femoral head. This then produces pain and loss of motion. This combination of pain and loss of motion in a major weight-bearing joint is particularly disabling.

The diagnosis is made on the basis of the history, and the physical and X-ray examinations. Pain resulting from hip joint disease is frequently present in the knee or anterior thigh. It tends to be aggravated by activity and relieved by rest. As hip motions become restricted, fixed deformities begin to develop, usually consisting of losses of internal rotation and extension and abduction. The patient most usually presents with a fixed flexion deformity, and with the hip in adduction and external rotation. Such a patient will often complain that the sound leg feels too long. Atrophy of the thigh musculature is always found. The differential diagnosis of disease in the lumbar spine or the sacro-iliac joints must be considered, but usually can be ruled out when the finding of specific limitation of motion in the hip joint is established.

Some of the X-ray findings have already been mentioned. The most common is narrowing of the hip joint space. Other changes to follow are sub-

chondral bone sclerosis with areas of cyst formation in both the femoral head and the acetabulum, and deformity of the femoral head with osteophyte formation and areas of bony collapse. Characteristically, one sees superior and lateral subluxation of the femoral head which is secondary to the defomity in the head and also to the formation of bonc within the acctabulum.

There are no specific laboratory findings in osteoarthritis. Studies to rule out gout, rheumatoid arthritis, and the connective tissue disorders should be carried out.

Once the diagnosis of osteoarthritis has been established, then the problem of management and treatmcnt arises. Many factors must then bc taken into consideration: the age, sex, occupation, body habitus, and the wants and desires of the patient. In any patient with established osteoarthritis of the hip, medications in common usage such as, indomethacin *(Indocin),* phenylbutazone *(Butazolidin),* and similar compounds are of no permanent benefit, although they may afford temporary relief. The use of systemic corticosteroids is specifically contraindicated in this condition.

The basic cornerstone of treatment should be to put the hip to rest and to provide appropriate analgesic medication, usually in the form of aspirin or aspirin-containing compounds. The hip is best put to rest in bed, until the symptoms subsidc. Traction, using skin straps, is sometimes necessary. Once the pain has been relieved and muscle spasm subsides, then the patient can be ambulated with crutches, using a three point gait if one hip is involved, or a four point gait if both hips are involved. Physical therapy in the form of moist heat and assisted active exercises is helpful. Special attention should be directed toward the prevention of fixed deformities and the preservation of strength in the important abductor muscles of the hip. Hydrotherapy, the usc of a warm pool, and swimming are all helpful adjuncts in treatment. Once the symptoms have been controlled, then the patient often can be advanced to a canc which is best carried in the hand opposite the affected hip. When this patient cannot achieve sufficient freedom from pain or when limited motion or deformity is so severe as to be disabling, then surgery usually becomes necessary.

At the prescnt time, the two basic approaches to the surgical treatment of osteoarthritis of the hip are osteotomy and arthroplasty. Osteotomy means to cut a bone, and arthroplasty means to make a joint. For the sake of completeness, two othcr procedures have been employed in the treatment of osteoarthritis of the hip. These are hip fusion and hip joint resection with or without osteotomy.

Hip fusion has been recommended in younger patients where there is unilateral disease without the likelihood of arthritis developing in the other hip. This is most likely to occur in those situations where the arthritis in the involved hip is secondary to trauma, or to some other older developmental condition which has run its course. Hip fusion can be accomplished by a variety of methods. When the hip is fused, then excess strain is imposed upon the other joints in the weight bearing chain, in order to allow the patient to be sufficiently mobile. These other joints are the lumbar spine, the sacro-iliac joints, and the knees. To some extent, the opposite hip is also involved. Successful fusion can be guaranteed to relicve pain, but loss of motion is the price that must be paid.

Joint rcsection, with or without osteotomy, involves removing the head and neck of the femur. When this is done without ostcotomy, it is known as a Girdlestone procedure, and when it is done with an abduction osteotomy (abducting the distal fragment), it is known as the Milch or Batchelor procedure. Both procedures are effective in relieving pain and producing mobilc hips, but stability of the joint for weight bearing is lost to a great degree. These procedures are most often performed in older patients who would not have the strength to tolerate the others, or they are performed as "salvage" procedures when other operations on the hip have failed.

The ostcotomy most frequently cmployed is a displacement intertrochanteric, one called a McMurray osteotomy. Here the femur is cut across just proximal to the lesser trochanter and thc distal fragment is displaced medially for a distance of one third to one half the diameter of thc shaft. Then the fragments are fixed with a device called a spline, which has a blade that penctrates the trochanteric bone, and a side plate that is screwed to the distal shaft.

The most successful form of arthroplasty is that where thc hip joint, or what is left of it, is opened and dislocated. Then the head of the femur and the acetabulum are reshaped with special tools so that they will be concentric with one another. Then a device called a cup or hip mold, which is made of vitallium steel, is interposed between the two bony surfaces. This cup is not fixed either to the femur or the acetabulum, but is free to move on the femoral head and in the acetabulum. The cup sits on the femoral head much in the way that a thimble fits on a thumb. The operation is combined with a total capsulectomy, debridement of the joint, and release of any contracted and deforming muscles such as the psoas. This muscle is not dicarded, but instead is moved to a more favorable position so that its function will not be lost.

The indications for osteotomy require, in addition to those for hip surgery, that the joint have a reasonable range of motion, usually more than 70 degrees of flexion and extension, and that the joint

be fairly congruous. If these conditions cannot be met, then arthroplasty is the procedure of choice. Pain relief is usually immediate following arthroplasty, but may require several months following osteotomy. The osteotomy usually requires three months to unite, during which time the patient uses crutches. After bony union has occurred, full weight bearing is allowed with the aid of a cane. Arthroplasty requires a period of protected weight bearing for at least one year, the first six months on crutches and the last six months with a cane. The range of motion does not usually improve or increase following osteotomy, but is expected to do so after a successful arthroplasty. Arthroplasty requires more of a patient than does osteotomy, because the patient has to learn to use his new hip and to care for it. This requires periods of exercise and rest, and patience. Chronological age is not a contraindication to arthroplasty, and there have been many successful arthroplasties performed on patients in their seventies.

The patient with osteoarthritis of the hip, by judicious management employing physical and medical aids, and by surgery when indicated, need not be consigned to a life of immobility and pain, or the confines of a wheelchair, but can look forward to relief of pain with restoration of the use and motion of that joint.

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION

ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE

DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily

Tuesday Evenings 7 to 9

355-9300

PATAPSCO AVENUE & FOURTH STREET

Baltimore, Maryland, 21225

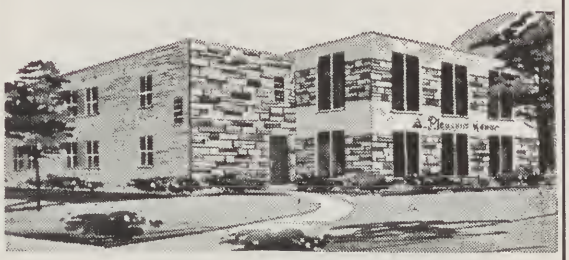
- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE EVANGELICAL PRESS

THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"

"The Best of Care for Those You Love"



Pleasant Manor

CONVALESCENT AND NURSING CENTER

ONE OF THE NEWEST, MOST MODERN PARA-MEDICAL FACILITIES

Round-the-clock care by Professional Staff
Complete Intensive Care Units
Physical and Occupational Therapy

Excellent Meals--Kosher Food on Request
Air-Conditioned, Fire-resistant Building
Centrally Located Near Sinai Hospital
Your Inspection Invited

4615 PARK HEIGHTS AVE.
BALTIMORE, MD.

542-4800

DOCTORS' OFFICES

LARGE

MEDIUM

SMALL

MEDICAL OFFICE BLDG.

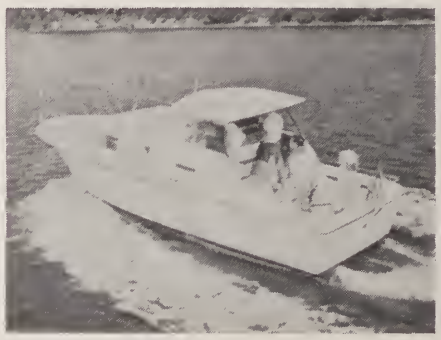
REASONABLE RENT

ELEVEN E. CHASE ST.

CORPORATION

11 E. Chase St.

Phone 539-8553



CONCORDE

The Custom Line of Fiberglas

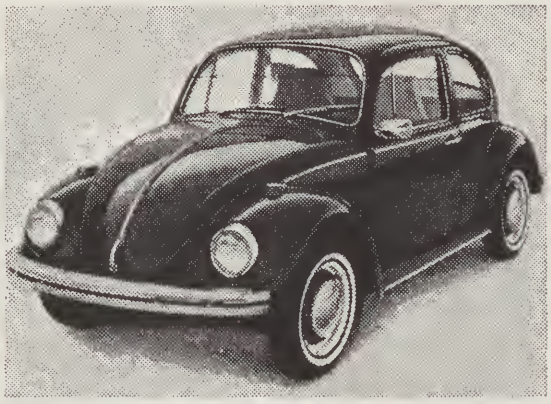
by *Brunswick*

27′ to 47′

VENTNOR MARINE SERVICE

Ventnor Road Pasadena, Md.

255-4100



Live below your means

If you'd like to get around the high cost of living, we have a suggestion.

Cut down on the high cost of getting around. And buy a Volkswagen. It's only **$1799***

* Suggested retail price east coast P.O.E. Local taxes and other dealer delivery charges, if any, additional.

MARYLAND VOLKSWAGEN

1212 E. 25th St.

(corner of Harford Rd.)

BALTIMORE, MD. Phone 889-7616

The World's Best $2000 Car stops with disc brakes straight, quick & sure!



It's yours for only $44 a month

Front disc brakes for safety! Fully independent rear suspension for comfort. Bucket seats and dozens of other extras, too.

DATSUN | 2

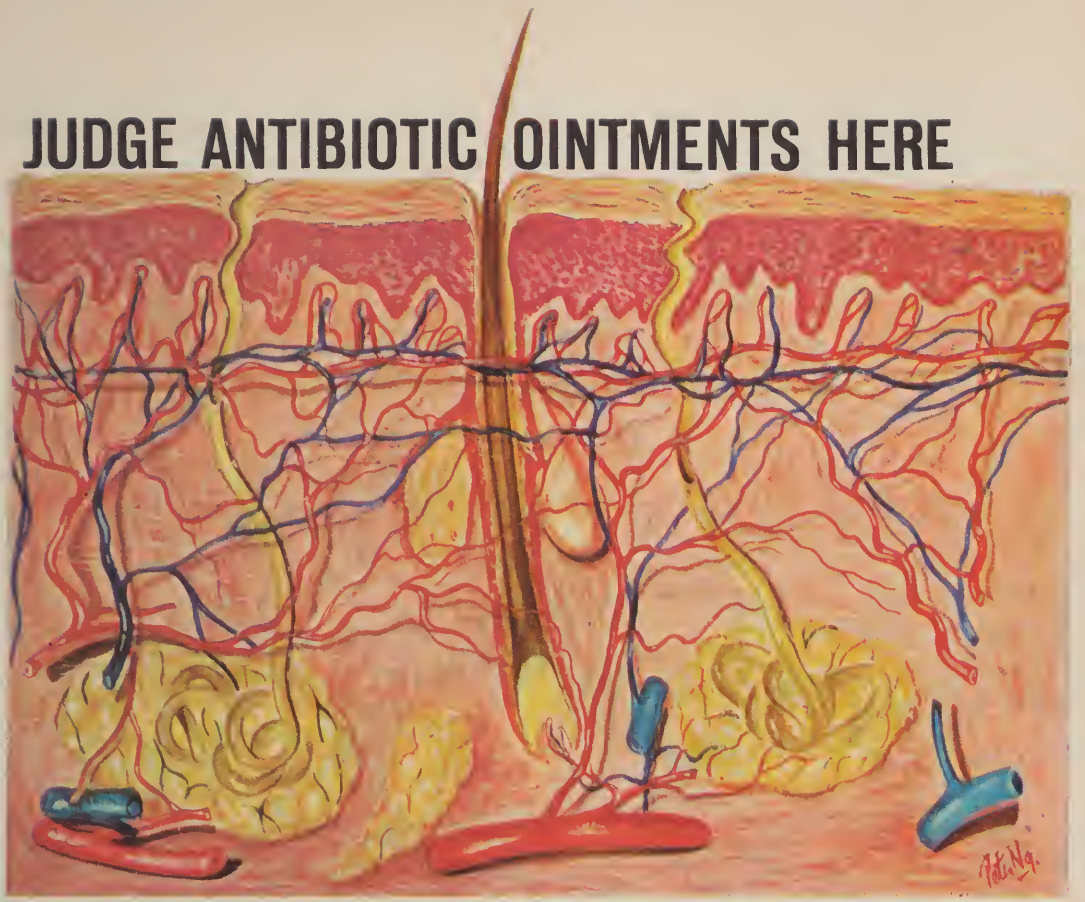
All colors and models in stock for immediate delivery!

TOWN & COUNTRY MOTORS

8021 Harford Rd. Baltimore, Md. 21234

665-7500

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and tol-

or here.



(ated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics, and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

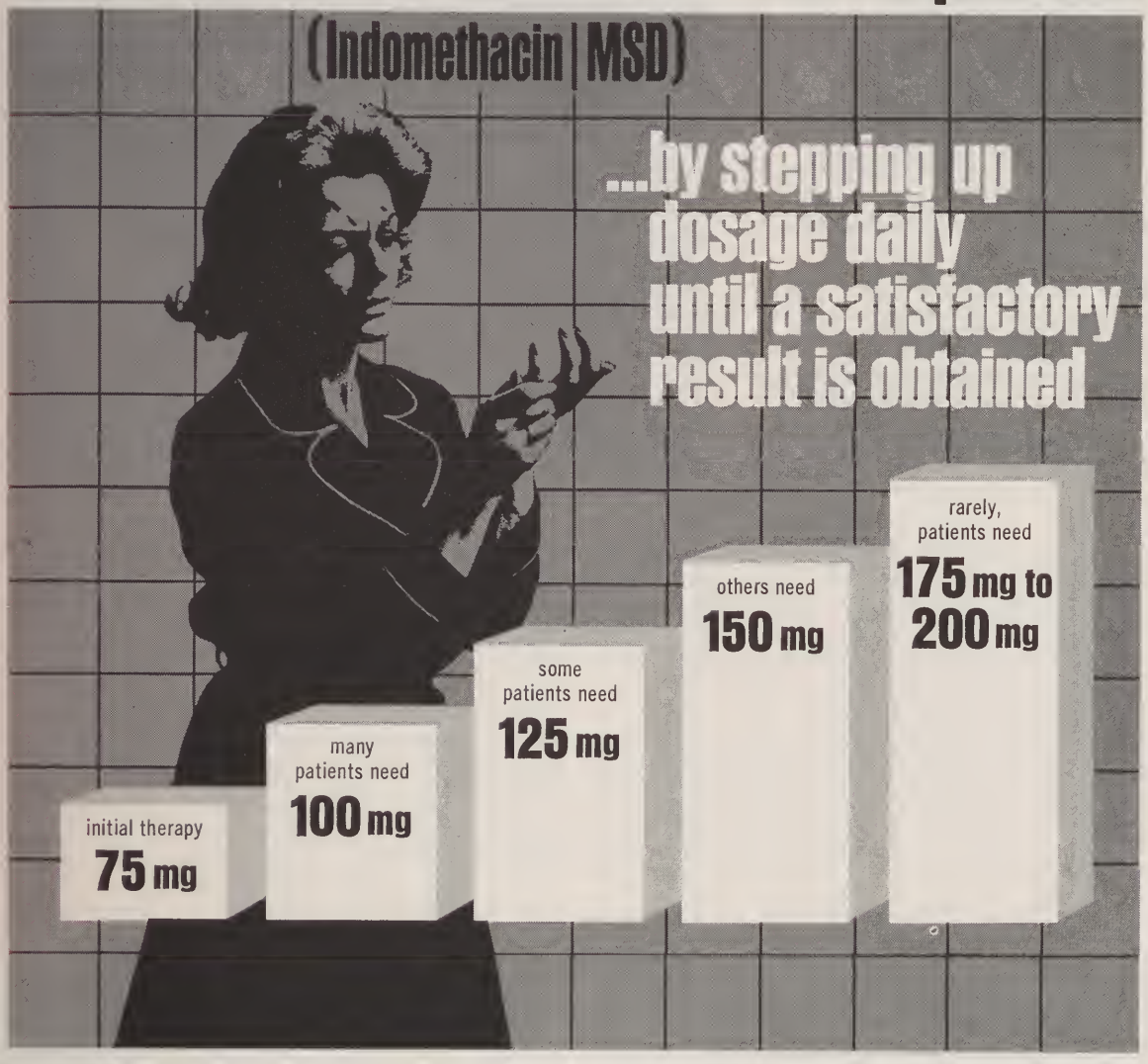
Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS

In selected cases of rheumatoid arthritis with acute symptoms

Response to INDOCIN® is often improved...



Many patients with acute rheumatoid arthritis or acute episodes of chronic rheumatoid arthritis can be controlled by increasing the dosage 25 mg *per day* (to the allowable maximum) until the episode subsides; the dosage should then be reduced gradually to maintenance levels. Few require the maximum (175–200 mg).

In the event the patient develops adverse effects, dosage should be reduced to tolerated levels for 2 or 3 days and then gradually increased by 25 mg every few days as tolerated. G.I. effects may be minimized by giving INDOCIN with food, antacids, or immediately after meals.

Now in two strengths
25 mg and 50 mg



Actual Size

INDOCIN®
(Indomethacin | MSD)

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under *Indications*. The drug should not be prescribed for children because safe conditions for use have not been established.

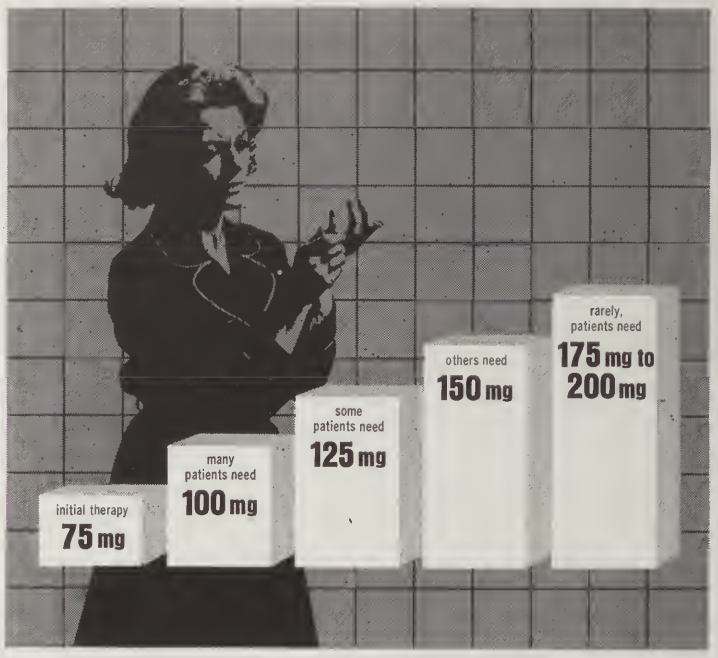
CONTRAINDICATED:

- in aspirin-sensitive asthmatics
- during pregnancy or lactation
- in children
- INDOCIN may mask the signs and symptoms of peptic ulcer and may cause ulceration or irritation of the G.I. tract. Therefore, do not give in active peptic ulcer, gastritis, regional enteritis, ulcerative colitis, and use with caution if there is a history of these disorders.

For additional prescribing information, please see following page.

In selected cases
of rheumatoid arthritis
with acute symptoms

Response to INDOCIN® (Indomethacin | MSD) is often improved by stepping up dosage daily until a satisfactory result is obtained



IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended under Indications. The drug should not be prescribed for children because safe conditions for use have not been established.

Indications: For the symptomatic treatment of rheumatoid arthritis, rheumatoid (ankylosing) spondylitis, degenerative joint disease (osteoarthritis) of the hip, and gout.

Contraindications: INDOCIN may mask the signs and symptoms of peptic ulcer and may itself cause peptic ulceration or irritation of the G.I. tract. For these reasons it should not be given to patients with active peptic ulcer, gastritis, regional enteritis, or ulcerative colitis (use with caution if there is history of these disorders); aspirin-sensitive asthmatics. Safe use during pregnancy or during lactation has not been established. Should not be prescribed for children because safe conditions for use have not been established. In a few cases of severe juvenile rheumatoid arthritis receiving INDOCIN along with other drugs, severe reactions, including fatalities, have been reported.

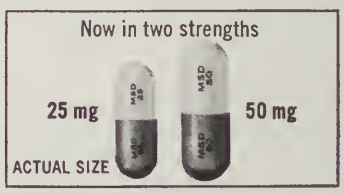
Warnings: Patients who experience dizziness, lightheadedness, or feelings of detachment on INDOCIN should be cautioned against operating motor vehicles or machinery, climbing ladders, etc. Use cautiously in patients with psychiatric disturbances, epilepsy, or parkinsonism since it may aggravate these conditions.

Precautions: Use cautiously in patients with a history of peptic ulcer, gastritis, regional ileitis, or ulcerative colitis because of its potential for causing G.I. bleeding. May cause single or multiple ulceration of the esophagus, stomach, duodenum, or small intestine, and, in a few Instances, severe bleeding and perforation with a few fatalities have been reported. May potentiate the ulcerogenic effect of steroids, salicylates, or phenylbutazone. Gastrointestinal bleeding with no obvious ulcer formation has also been noted; the drug should be discontinued if G.I. bleeding occurs. As a result of obvious or occult G.I. bleeding, some patients may manifest anemia, and for this reason periodic hemoglobin determinations are recommended. G.I. effects may be minimized by giving the drug with food or with antacids or immediately after meals. In common with other drugs that have anti-inflammatory, analgesic, and antipyretic properties, indomethacin may mask the signs and symptoms of infection; avoid undue delay in initiating appropriate treatment of the infection; use cautiously in patients with existing, but controlled, infections. As with any new drug, patients should be followed carefully to detect unusual manifestations of drug sensitivity.

Adverse Reactions: Starting therapy with low doses, with gradual increases when necessary, will minimize adverse reactions. *Central Nervous System:* Most commonly, headache (usually more severe in morning), dizziness, and lightheadedness; infrequently observed reactions include mental confusion, drowsiness, convulsions, coma, depression, and other psychic disturbances, such as depersonalization; CNS effects are often transient and frequently disappear with continued treatment or reduced dosage. The severity of these effects may occasionally require cessation of therapy. *Gastrointestinal:* Most commonly, nausea, anorexia, vomiting, epigastric distress, abdominal pain, and diarrhea; others that may develop are ulceration, single or multiple, of esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage with a few fatalities having been reported; G.I. bleeding without obvious ulcer formation, increased abdominal pain in patients with preexisting ulcerative colitis; less commonly, stomatitis; gastritis; bleeding from the sigmoid colon, occult in type or from a diverticulum, and perforation of preexisting sigmoid lesions (diverticulum, carcinoma); G.I. reactions not known definitely to be attributable to indomethacin include development of ulcerative colitis and of regional ileitis. *Hepatic:* Rarely, jaundice and hepatitis. *Cardiovascular-Renal:* Infrequently, edema, elevation of blood pressure, and hematuria. *Dermatologic-Hypersensitivity:* Infrequently, pruritus, urticaria, angioneurotic edema, angiitis, skin rashes, loss of hair, and acute respiratory distress including sudden dyspnea and asthma. *Hematologic:* Infrequently, leukopenia, purpura, and thrombocytopenia; rarely, agranulocytosis and bone marrow depression have been reported, but a definite relationship to the drug has not been established; since some patients may manifest anemia secondary to obvious or occult G.I. bleeding, periodic hemoglobin determinations are recommended. *Eye-Ear:* Infrequently, tinnitus, blurred vision, hearing disturbance, and orbital and periorbital pain. *Miscellaneous:* Rarely, vaginal bleeding, hyperglycemia, and glycosuria.

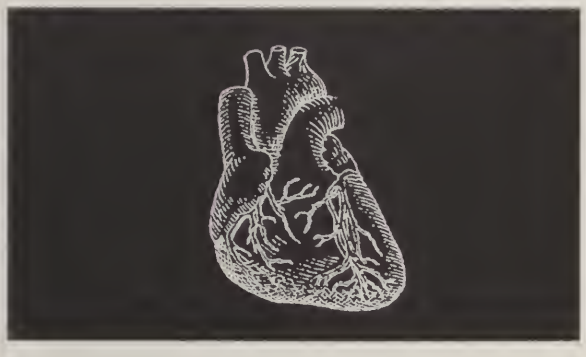
Supplied: Capsules containing 25 mg indomethacin each, in bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in bottles of 100.

For more detailed information, consult your Merck Sharp & Dohme representative or see the package circular.



MSD **MERCK SHARP & DOHME** Division of Merck & Co. Inc. West Point Pa 19486

WHERE TODAY'S THEORY IS TOMORROW'S THERAPY



JERRY SALAN, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Antibiotic Chemoprophylaxis in Cardiac Surgery

MORTON I. RAPOPORT, MD
Assistant Professor of Medicine

ROLENDO SABUNDAYO, MD
Fellow in Medicine

Division of Infectious Diseases
Department of Medicine
University of Maryland School of Medicine

Infection remains the most serious complication of modern cardiovascular surgery. The factors, which in large measure contribute to this problem, include cardiopulmonary bypass, use of synthetic graft materials, ambitious corrective procedures requiring prolonged surgery, and massive transfusions. However, infectious complications are not to be viewed as reasons for not performing cardiovascular surgery, but rather as undesirable sequels which, presumably, can be prevented.

The most feared and clearly the most catastrophic form of postoperative infection is that of endocarditis. This infection may occur as a result of bacteremia induced either from the bypass apparatus itself, intravenous catheters, or from numerous other sites. On the other hand, the occurrence of bacteremia cannot be invoked as the primary cause of postoperative endocarditis since it has been established that numerous host factors are altered in these patients. Impaired phagocytic functions, lysosomal disruption, and white cell destruction have all been observed to varying degrees in patients after cardiopulmonary bypass.

The organisms most frequently encountered in this form of infection have been staphylococci, although streptococci, pneumococci, and gram-negative organisms (including salmonella, klebsiella and E. coli) have been seen with increased frequency. Isolated reports of postoperative endocarditis due to various species of diphtheroids are also appearing with increased frequency. Finally, fungal infections, especially candidiasis, have been encountered in this setting.

Once endocarditis has become an established fact in the postoperative cardiac surgery patient, the disease assumes a fulminant course. In spite of early specific antimicrobial administration, the mortality rate remains high. Frequently reoperation, requiring removal or replacement of prosthetic valves, and removal of suture material or other graft material, is necessary in order to assure success of the chemotherapeutic program.

While the issue has not been settled with any degree of finality, it does seem that antibiotic chemoprophylaxis may be efficacious in preventing infectious complications of cardiac surgery. Most investigators agree that a significant reduction in the incidence of postoperative endocarditis can be achieved by a program of antibiotic administration beginning 12-24 hours preoperatively and lasting five to ten days postoperatively. A study in progress at our hospital has tended to confirm this observa-

tion. Our own observations, in agreement with others, have established that different chemoprophylactic regimens are effective. However, the inclusion of a penicillinase resistant penicillin seems to be most important, since the most commonly isolated organisms in this form of endocarditis have been penicillin-resistant staphylococci. Virtually all of the chemotherapeutic programs in use stress the importance of effective antibiotic blood levels at the time of surgery, since this appears to be the most vulnerable period during which the infecting organisms become engrafted.

Unfortunately, the data accumulated, regarding endocarditis in post-cardiac-surgery patients and the efficacy of chemoprophylaxis, have been erroneously applied to other forms of cardiovascular manipulation. Some clinicians have suggested that data obtained in post-cardiac-surgery patients are relevant to patients undergoing cardiac catheterization, pacemaker insertions, etc. This is clearly not the case, since no data thus far have been able to establish any effectiveness for antibiotics in this setting.

In summary, while the data should at this time be interpreted with some degree of caution, it would appear that cardiac surgery is one of those few forms of surgery in which antibiotic chemoprophylaxis may play a role in infection prevention.

SKILL SURGICAL, INC.

S K I L L
SKILL

SUPPLIES & EQUIPMENT
for
PHYSICIANS—SURGEONS
HOSPITALS

5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

Baltimore's most unusual dining place!

Famous
Owl Room



Belvedere Hotel
Charles & Chase Streets

Al-Lin Ambulance Service
"AT THE BELTWAY"
4811 E. LEEDS AVE. BALTIMORE, MD. 21227
24 Hour Emergency Ambulance and Oxygen Service
Trained and Experienced Personnel
2 Way Radio Controlled
247-2111

MYRTLE SEIDEL
Antiques
ANTIQUE JEWELRY ★ GLASS ★ CHINA ★ FURNITURE
Imported Christmas Cards
Mulberry 5-8851 1015 North Charles St.
Baltimore, Md. 21201

R M K

Insurance For The Doctor
PROFESSIONAL LIABILITY*
Workmen's Compensation
Equipment Floater
Bonds on Employees
Public Liability
Fire Insurance
Disability Income
Term Life Insurance
Pension Plans
* *Endorsed by MEDICAL SOCIETY OF D. C. & MD.*

Russell, Marsh & Kennedy, Inc.
5151 WISCONSIN AVE. WASHINGTON, D. C. 20016 244-7600

College To Establish Registry Of Organ Transplantations

The American College of Surgeons has been requested by the National Institutes of Health to establish and administer a registry of human transplantation cases performed in the United States. Transplantations performed abroad may also be included, pending negotiations now being conducted between the college and federal agencies.

The transplantation registry, which will be housed at college headquarters under the supervision of a transplant coordinator, will include the heart, liver, lungs, spleen, pancreas, thymus, gonads, and bone marrow. Kidney transplants, which are already being monitored by an effective kidney transplant registry, will not be included.

The broad objectives of the transplantation registry are: to provide a firm, reliable mechanism for recording biologic information on transplantations already performed; to share rapidly accumulating transplant data on a worldwide basis; to avoid widespread repetition of individual misadventures, and to point out favorable avenues for further investigation.

An ad hoc committee appointed by the Board of Regents will assist the college and NIH in the development of the registry. The committee consists of C. Rollins Hanlon, St. Louis, chairman; J. Englebert Dunphy, San Francisco, and William P. Longmire, Jr., Los Angeles.



BOLTON HILL *Dinner Theatre*

"ONCE MORE WITH FEELING"
June 3 — June 29

"STAR SPANGLED GIRL"
July 1 — July 27

Dinner — 8:30 P.M.
FREE PARKING
CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
11:30 AM 2 AM

for Reservations
call 728-0800

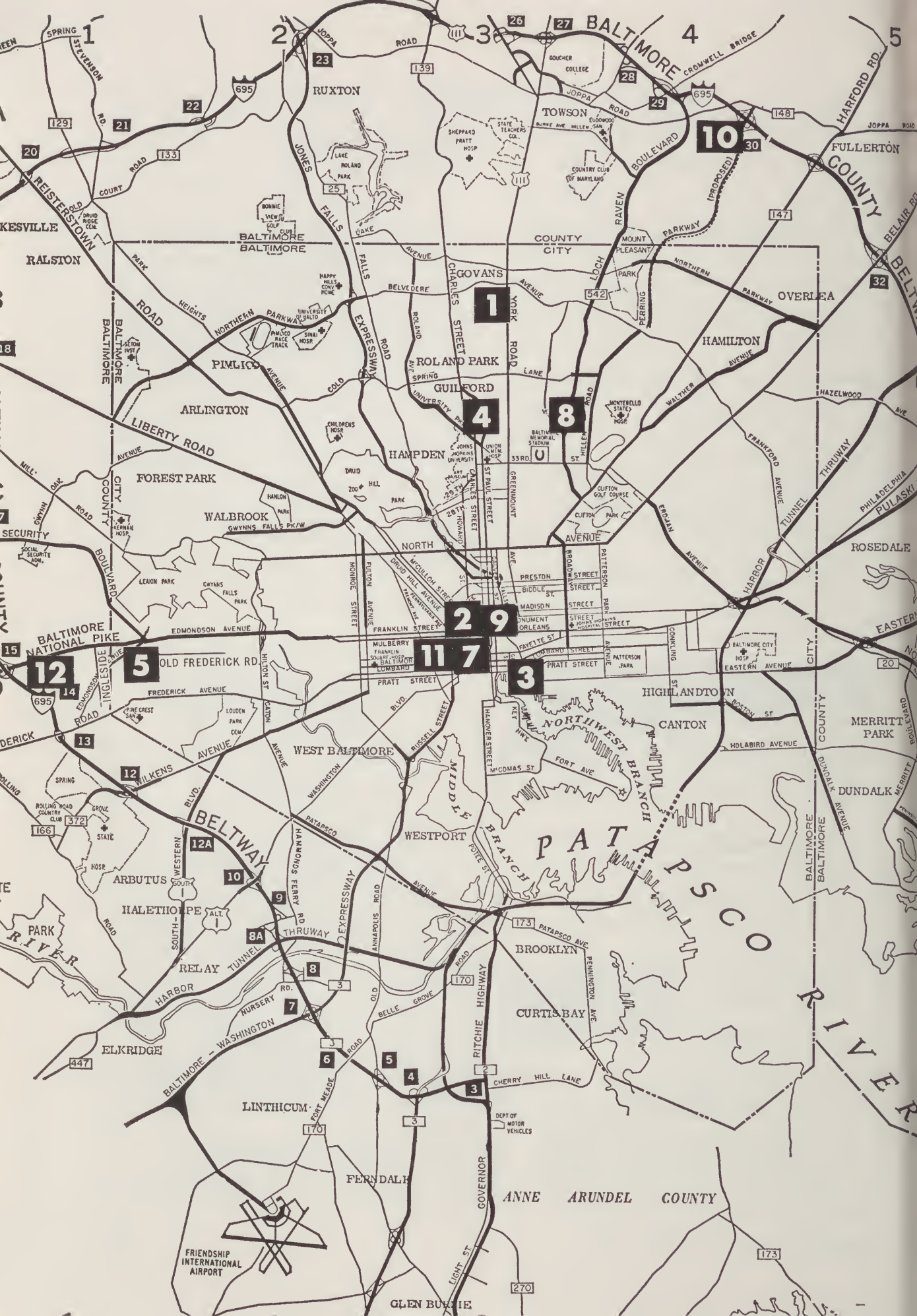
Luncheon Served 11:30 AM-2 PM
Luncheon Fashion Show Every Thursday
Baltimores Only Professional Dinner Theatre

FOOD AND DRUG ADMINISTRATION

Bureau of Medicine
IS SEEKING

- **PHYSICIANS**—Board certified or Board eligible in various specialties.
- **The Board of Medicine,** one of the major divisions of FDA, is responsible for developing medical policy on the efficacy and safety of drugs, medical devices, and substances used in foods, drugs, cosmetics, and hazardous household products. The individual physician is assigned to one of four major subdivisions of the Bureau and reviews and evaluates scientific and clinical data relating to safety and efficacy of drugs, medical devices, and substances.
- **Starting salary $19,771** with assured periodic increases; excellent fringe benefits; professional development programs; equal opportunity; U.S. citizenship required. (The proposed pay increase would raise the starting salary to approximately $21,600 in July 1969 if approved.)
- **Located in Arlington, Virginia** in modern office-apartment-shopping complex.
- Major relocation expenses reimbursed.
- Submit brief resume or for complete information submit inquiry to:

BUREAU OF MEDICINE
Code A-16 P.O. Box 2000
Eads Station, Arlington, Virginia 22202


BALTIMORE
BALTIMORE COUNTY
ANNE ARUNDEL COUNTY
RUXTON
TOWSON
FULLERTON
RALSTON
PIMLICO
ARLINGTON
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
OVERLEA
HAMILTON
FOREST PARK
WALBROOK
NORTH
ROSEDALE
HIGHLANDTOWN
CANTON
MERRITT PARK
DUNDALK
WEST BALTIMORE
WESTPORT
BROOKLYN
CURTIS BAY
ARBUTUS
HALETHORPE
RELAY
ELKRIDGE
LINTHICUM
FERNDALE
GLEN BURNIE
PATAPSCO RIVER
NORTHWEST BRANCH
MIDDLE BRANCH
PARK RIVER
FRIENDSHIP INTERNATIONAL AIRPORT
BELTWAY
JOPPA ROAD
LIBERTY ROAD
REISTERSTOWN ROAD
YORK ROAD
CHARLES STREET
GREENMOUNT AVENUE
HARFORD RD.
COUNTY
BELTWAY
BALTIMORE NATIONAL PIKE
OLD FREDERICK RD.
EDMONDSON AVENUE
FREDERICK AVENUE
PRATT STREET
FRANKLIN STREET
MULBERRY
LOMBARD
PRESTON
BIDDLE ST.
MADISON
FAYETTE ST.
PATAPSCO AVE.
HOLABIRD AVENUE
BOSTON ST
EASTERN AVENUE
PATTERSON PARK AVENUE
HARBOR TUNNEL THRUWAY
FRANKFORD AVENUE
PHILADELPHIA
PULASKI
HAZELWOOD AVE
WALTHER AVENUE
NORTHERN PARKWAY
MOUNT PLEASANT PARK
LOCH RAVEN BOULEVARD
RAVEN
PARKWAY (PROPOSED)
COUNTRY CLUB OF MARYLAND
STATE TEACHERS COL.
SHEPPARD PRATT HOSP
GOUCHER COLLEGE
CROMWELL BRIDGE
LAKE ROLAND PARK
JONES FALLS EXPRESSWAY
CHARLES STREET AVENUE
ROLAND AVENUE
UNIVERSITY PARKWAY
JOHNS HOPKINS UNIVERSITY
UNION MEM. HOSP.
BALTIMORE MEMORIAL STADIUM
33RD ST
29TH ST
28TH ST
ST PAUL STREET
GREENMOUNT AVE
HOWARD STREET
CHARLES STREET
DRUID HILL AVENUE
MONUMENT STREET
ORLEANS STREET
JOHNS HOPKINS HOSPITAL
BALTIMORE CITY HOSP
PATTERSON PARK
CONKLING
MONTEBELLO STATE HOSP
CLIFTON GOLF COURSE
CLIFTON PARK
ERDMAN AVENUE
HARBOR
EASTERN
CITY
COUNTY
BOULEVARD
MERRITT
DUNDALK AVENUE
PENNINGTON AVE.
BALTIMORE
BALTIMORE
HANOVER STREET
KEY HWY
FORT AVE
McCOMAS ST
RUSSELL STREET
WASHINGTON BLVD.
PATAPSCO
WILKENS AVENUE
HILTON ST
CATON AVENUE
INGLESIDE AVENUE
EDMONDSON ROAD
LOUDEN PARK CEM.
PINE CREST SAN.
LEAKIN PARK
GWYNNS FALLS PARK
GWYNNS FALLS PK/W
KERNAN HOSP.
SECURITY BOULEVARD
SOCIAL SECURITY ADM.
MONROE STREET
FULTON AVENUE
DRUID HILL AVENUE
McCULLOH STREET
PENNSYLVANIA AVE.
HOWARD STREET
CHARLES STREET
ZOO
DRUID HILL PARK
HANLON PARK
CHILDRENS HOSP.
SINAI HOSP.
PIMLICO RACE TRACK
UNIVERSITY OF BALTO.
HAPPY HILLS CONV. HOME
BONNIE VIEW GOLF CLUB
DRUID RIDGE CEM.
LAKE ROLAND PARK
WAKE AVENUE
BELVEDERE AVENUE
COLD SPRING LANE
MILL OAK ROAD
GWYNN
SPRING GROVE STATE HOSP.
ROLLING ROAD COUNTRY CLUB
WESTERN SOUTH-BOUND
SOUTH ALT. I
HAMMONDS FERRY RD.
ANNAPOLIS ROAD
OLD BELLE GROVE ROAD
RITCHIE HIGHWAY
PATAPSCO AVE.
CHERRY HILL LANE
NURSERY RD.
HARBOR TUNNEL THRUWAY
BALTIMORE - WASHINGTON BLVD.
FORT MEADE
DEPT OF MOTOR VEHICLES
LIGHT ST.
GOVERNOR
COURT ROAD
REISTERSTOWN ROAD
JOPPA ROAD
BELAIR RD.
HARFORD RD.
CROMWELL BRIDGE
1
2
3
4
5
695
129
133
139
148
147
542
166
372
447
170
173
270
20
21
22
23
25
26
27
28
29
30
32
18
15
14
13
12
12A
10
9
8A
8
7
6
5
4
3
2

Restaurants of Distinction

Locations indicated by numbers on map

11

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*



Your Host
Tom d'Anna

539-9021

12

Dobbs House

Breakfast-Luncheon-Dinner
Banquets-Meeting-Private Parties
We Cater Wedding Receptions

Located in Quality Court Motel—West
U.S. Route 40 & Beltway Exit 15
5801 Baltimore National Pike

744-1510

7

Miller Bros.

"The Place to Eat"

NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call **752-4822**

6

MILTON INN

Circa 1740

Dine Amid Early American Charm
Warm, Gracious and Inviting

Selected By Life & Time Magazines as One of America's Finest Inns

Lounge & Dining Room Available for Private Parties

ATTILIO ALLORI, Owner

Mi. North of Cockeysville on York Rd.

SARKS **771-4366**

3

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

Baltimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center
Open 12 noon to 3 A.M.—Closed Mondays

For Reservations Call **685-2811**

2 blocks south of the Flag House
300 ALBEMARLE STREET

4

Broadview Restaurant

Cocktails • Dinners • Luncheons
Private Entertaining Facilities
116 W. University Parkway at 39th St.
CALL CH 3-1216



SPECIAL AT THE

FABULOUS CLUB VENUS

An Evening for Two . . Only **$15**

Offer good every night except Saturday
Make Reservations Now
Perring Plaza Shopping Center—Beltway Exit 30
For Reservations Call **NO 8-2232**

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE
Baltimore 1, Md. **MU 5-6790**

CARRY-OUT SERVICE
SPECIAL LUNCHEON and DINNERS
PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.
Sunday 12 Noon to 3 A.M.

5



Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS
Finest Sea Foods
Prime Meats

5653 Old Frederick Road
East of Ingleside Ave., off Baltimore National Pike

TED KUCHTA, *Manager* Phone 744-0223

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD
Cocktails **Mexican Beers**

Tuesday thru Sunday
Open 5:00 P.M.---12:00 P.M.
Dinner and Snacks
Closed Monday

Phone 435-9858

9

Cork 'n Bottle Restaurant

STEAK — SEAFOOD — PRIME RIB
COCKTAILS
LUNCHEON — DINNER

Major Credit Cards Honored
Private Party Rooms

22 E. FAYETTE ST. BALTIMORE, MD.
½ Block from Charles Center

539-1268

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because
in 3 to 5 days
she can often begin
to cope,
work,
maybe play,
even enjoy.

Pertofrane®

desipramine hydrochloride
In depression...
when words are not enough

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

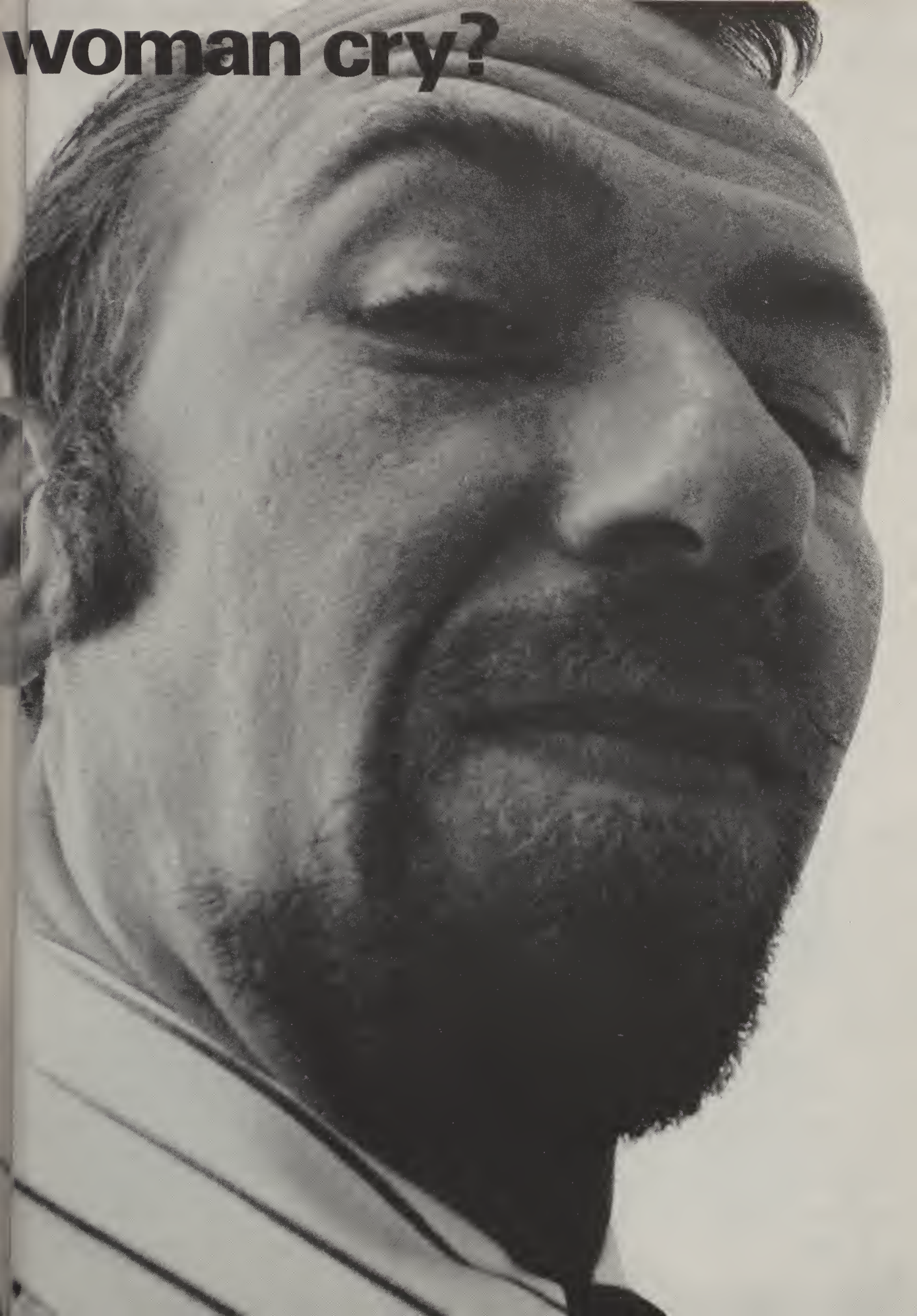
Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

woman cry?



STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

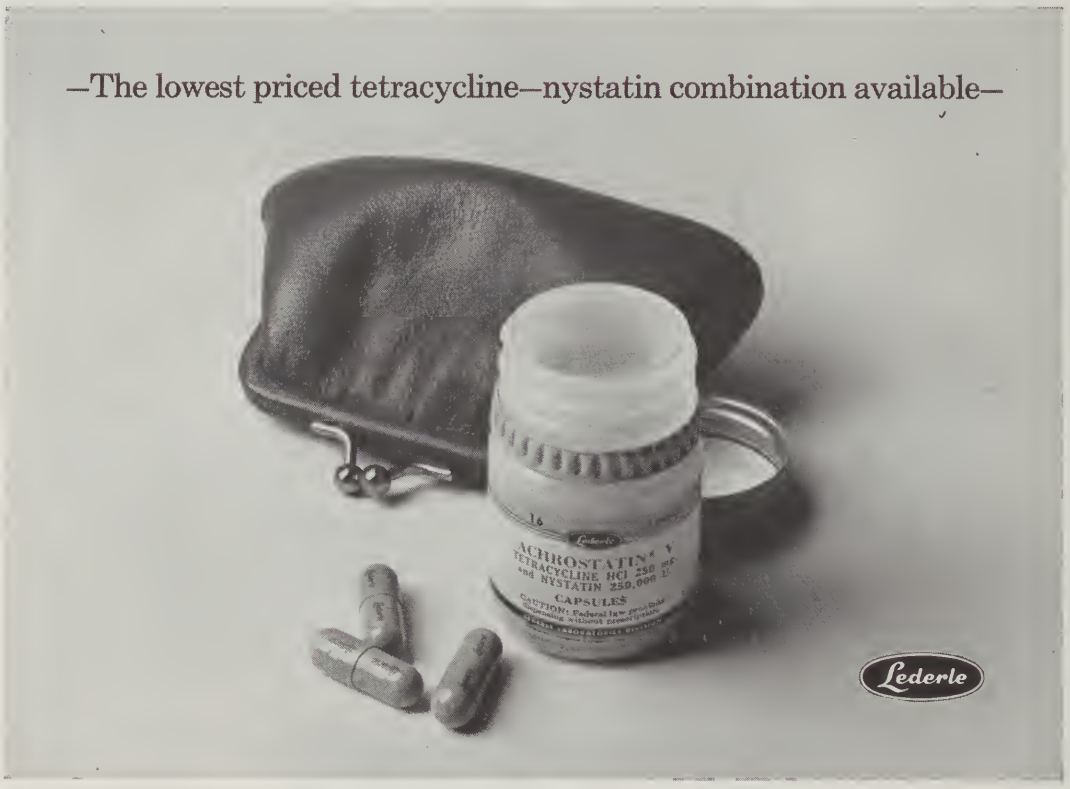
We Repair and make Lamps
"Lamps make the home Beautiful"
LE 9-0222 403 N. Charles Street
Baltimore, Md. 21201

COLOSTOMY
ILEOSTOMY
Appliances and Disposable Bags
CALL
FIELDS PHARMACY
IN PIKESVILLE
for convalescent supplies and service
FOR RAPID DELIVERY **486-3300**

Do Your Patients Need Nursing Service?
Call **889-5666**
COBB-WOODS SERVICES
Vera Woods, M. A. Director
2213 St. Paul St. Baltimore, Md. 21218
Licensed by the State of Md.

MERCEDES-BENZ
Baltimore's only Authorized Dealer for Sales, Service and Parts
R. & H. Motors, Inc.
4810 Belair Rd. 426-9200
Baltimore, Md. 21206

—The lowest priced tetracycline—nystatin combination available—



Find Your Place In the Sun

Mario's
Specializing in
ITALIAN ★ AMERICAN
FOOD
CONTINUOUS ENTERTAINMENT
IN OUR INTIMATE
Cocktail Lounge
Phone AT 9-9445
OCEAN CITY, MD.

Resort Advertisers in This Issue

Easton
Walsh and Benson 139

Ocean City
Beach Plaza Hotel/Bo-Con Apartments ... 138
Diplomat Motel 138
Harrison Hall 138
Mario's Restaurant 137
Stowaway Motel 138

Rehoboth Beach
Atlantic Sands Motel 139
Stewart Kingston Galleries 139

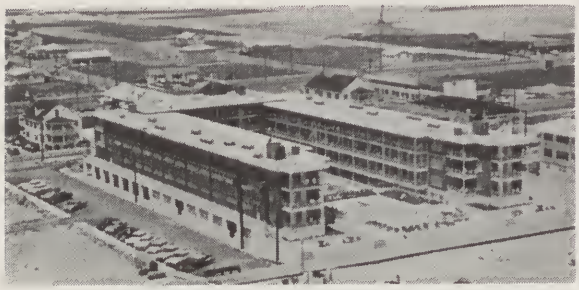


OCEAN CITY CONVENTION HALL UNDER WAY

Completion of the Convention Hall now under construction will provide Ocean City with one of the most beautiful facilities of its kind on the east coast. Long favored as a convention center because of its many fine hotels and motels, Ocean City will now have ideal accommodations for large conventions, sales meetings, trade shows, private parties and banquets, as well as cultural and sporting events.

The Convention Hall will accommodate 3100 people for a convention, and approximately 2000 for a banquet. On either side of the main arena will be ten meeting rooms seating from 50 to 300. Exhibit space is provided both in a large hall and individual booths. Parking area for 950 cars, with sheltered loading is to be provided. Completely modern, air-conditioned and heated, Convention Hall will undoubtedly be a busy center of activity in all seasons.

DIPLOMAT MOTOR HOTEL



Largest, Most Luxurious Units on Beach

Bedroom and Efficiency Units

● CONTINENTAL CUISINE ●

Food Prepared by our Chef for
the Most Discriminating Connoisseurs

100% Air Conditioned

- Swimming Pool
- Dining Room
- Cocktail Lounge
- Coffee Shop

. . . and you get TV in every room

WE CATER TO CONVENTIONS – *Accomodations for small groups, up to 300 persons*

Boardwalk at 26th W
Telephone 289-7148

OCEAN CITY
MARYLAND

HARRISON HALL



Finest Resort Hotel in Maryland

117 OCEAN COOLED ROOMS

Open through September

CONVENTION FACILITIES — ELEVATOR SERVICE
OCEAN DINING ROOM — EUROPEAN PLAN
PRIVATE BATH IN EVERY ROOM
GOLF PRIVILEGES • COCKTAILS • FREE PARKING
NEW OLYMPIC SIZED SWIMMING POOL

Mrs. G. Hale Harrison, Manager-Owner

BOARDWALK AT 15TH ST. — OCEAN CITY, MD.
Phone AT 9-6222

BEACH PLAZA HOTEL
BO-CON APARTMENTS

and Efficiencies

Fully Air-Conditioned and Heated



Dining Room, Coffee Shop & Bar

- 200 feet on Ocean Front with Guarded Beach
- Free Off-Street Parking
- TV and Telephone in Every Room and Apartment
- Telephone on Beach
- Delicious Food and Soft Music in our Air-Conditioned Dining Room
- Golf Privileges
- Color TV in Lounge



BOARDWALK AT 13th ST., OCEAN CITY, MD.
Phone: 289-9121

The BIG One On The Ocean

Ocean City, Md.

Stowaway MOTEL

21st to 22nd St. & BOARDWALK



"The Stowaway Has Everything"

- One full block of beautiful beach
- Air Conditioning • Free Parking
- 120 Units, 33 Efficiencies
- Children's Pool • Color TV Room
- Magnificent Olympic-size Pool
- Restaurant and Cocktail Lounge
- Free TV in every room • Supervised Beach
- European Cuisine

For Reservations—Call ATlantic 9-6191

STUART KINGSTON GALLERIES



THE ROYAL SHAH KERMAN CARPET

Finest in all the world

Exclusively at Stuart Kingston Galleries

AUCTION SALES NIGHTLY – 8 P.M.

The First Gallery in the First State

Exhibition hours – 10 A.M. – 4 P.M.

Phone (302) 227-2524

On the Boardwalk—REHOBOTH BEACH, DEL.

Drownproofing

Teach your child drownproofing.

Drownproofing, according to the Health Insurance Institute, consists of a series of arm and leg movements that help a person move up and down instead of forward.

Detailed instructions for teaching this technique to youngsters are now being provided on a new wallet-sized card published free of charge by the U.S. Public Health Service.

If performed correctly, reports the PHS, it will allow a child to survive in the water for hours, even if it is rough.

The PHS card, "Safety Tips In-Out-and-Around the Water" may be obtained free in quantities up to 100 by writing to the Injury Control Program, National Center for Urban and Industrial Health, 222 East Central Parkway, Cincinnati, Ohio 45202.



For the Best in Leisure Living

Enjoy a vacation at the

Atlantic Sands
MOTEL

Boardwalk and Baltimore Ave.

REHOBOTH BEACH, DELAWARE

- 80 FINE ROOMS
- AIR CONDITIONED
- TELEVISION
- BEACH SHOP
- HEATED POOL
- TELEPHONE SERVICE
- RESTAURANT
- ELEVATOR SERVICE

OPEN ALL YEAR LONG!

Write for Reservations . . . . . or

Phone **(302) 227-2511**



"Peach Orchard Point"

BEAUTIFUL WATERFRONT ESTATE

Beautifully located on the Miles River, just 5 miles west of Easton, this charming 7-acre estate has a spacious residence of Colonial Brick, with 4 bedrooms, 3 tile baths, living room with fireplace, "living kitchen" with attached den & fireplace, large screened porch overlooking "Peach Orchard Cove." Entire waterfront bulkheaded; 75 ft. pile driven wharf; protected anchorage adequate for most any vessel.

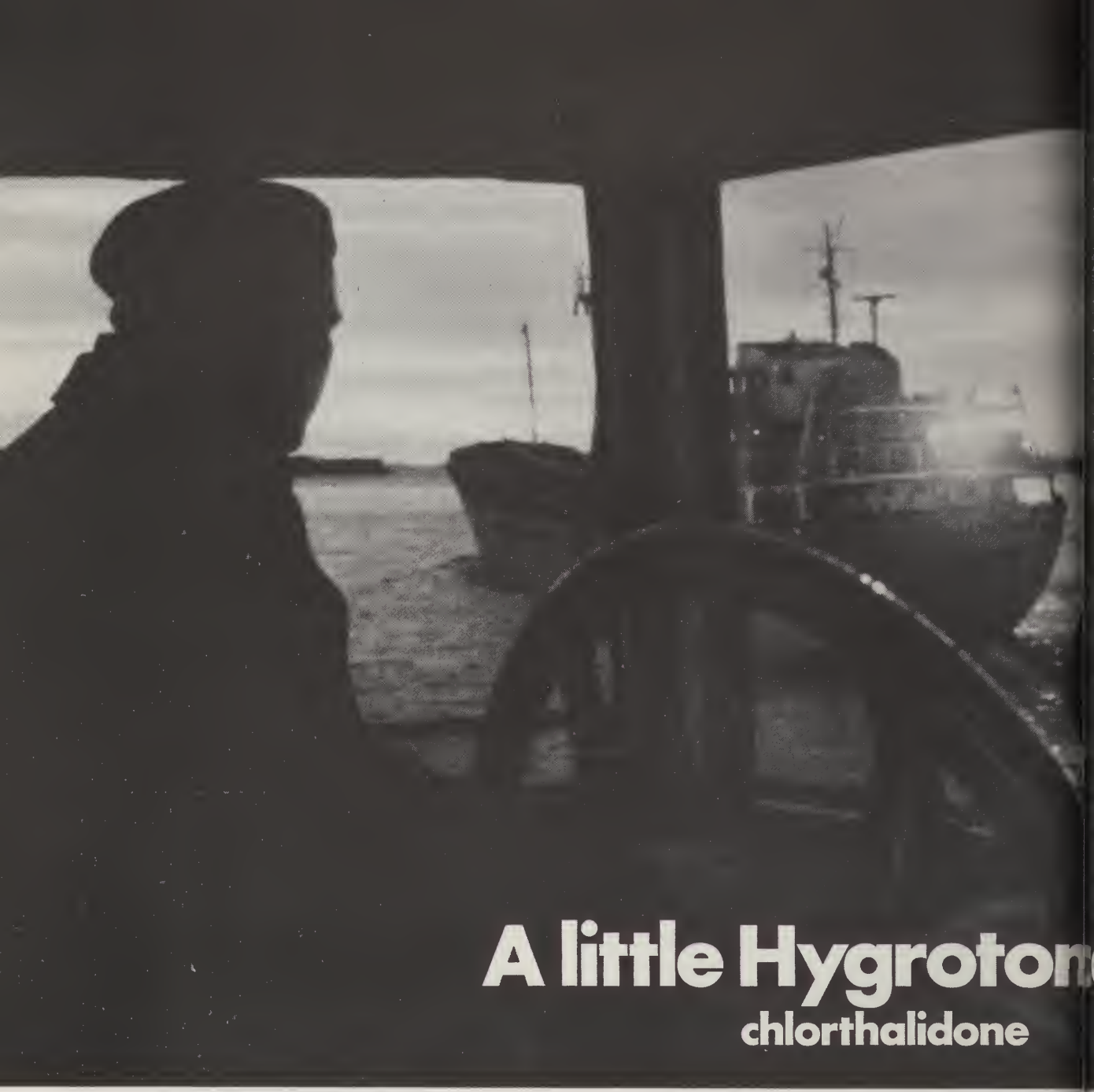
EXCLUSIVE AGENTS

Walsh & Benson, Inc.

REALTORS

301 – 822-1415

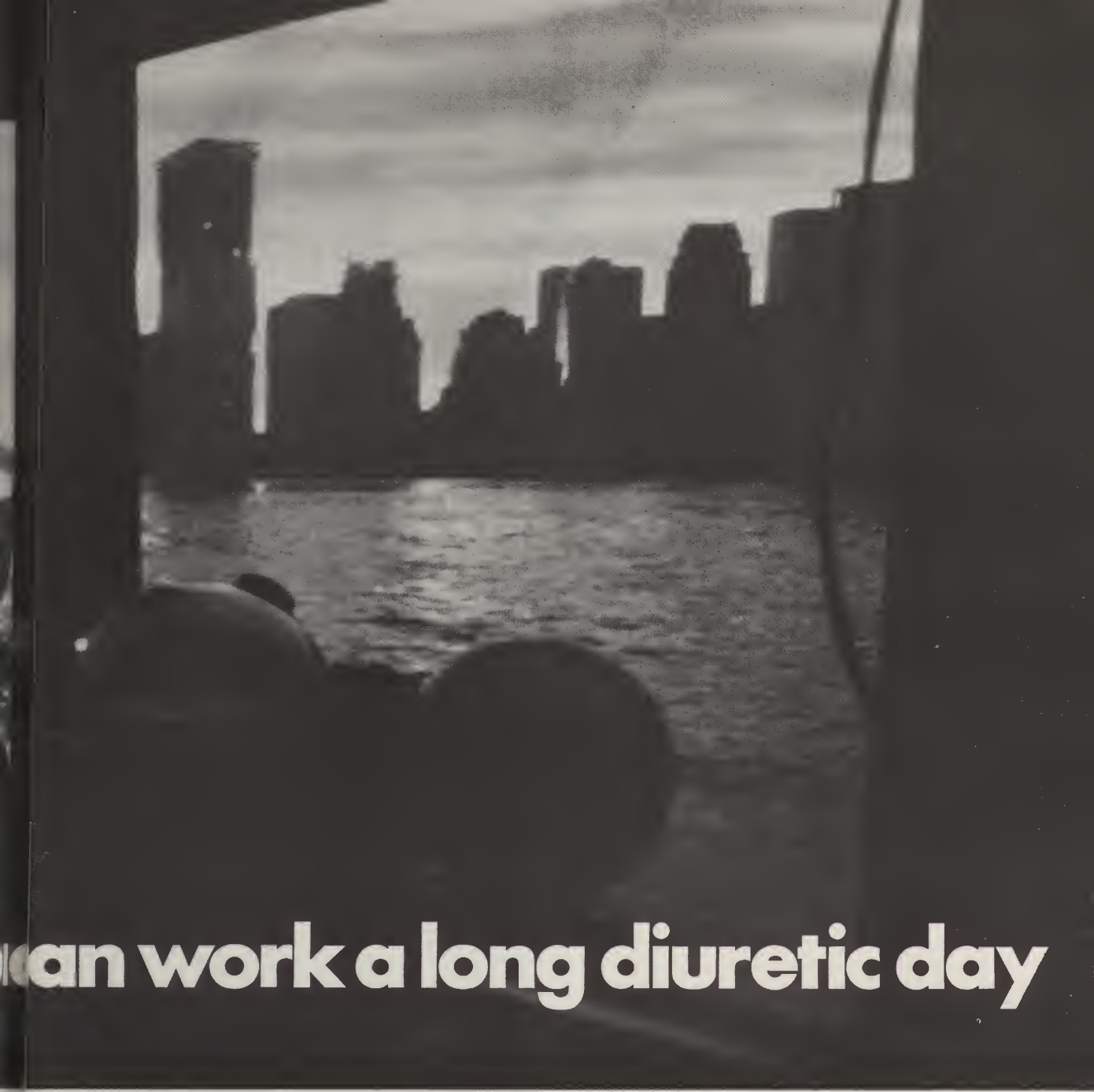
EASTON, TALBOT COUNTY, MD.



A little Hygroton

chlorthalidone

MY-6674



an work a long diuretic day

the way from one daily tablet to the next
help control edema and hypertension

prolonged action usually provides smooth, sustained diuretic
ectiveness; real one-a-day dosage, right from the start; convenience
d economy.

ygroton, chlorthalidone, can cause side effects. And it's contra-
dicated in hypersensitivity to the drug and severe renal and
epatic diseases.

heck the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

MY-6574

Skilled Hands For The O.R.

The shortage of professional nurses to assist the surgeon at the operating table is an old story now. There is no reason to hope that it will ever be overcome. In fact, with the closing of many hospital based schools for nurses and the reduced time alloted for actual operating room experience in the remaining nurses training courses, it is certain that this personnel shortage will grow worse.

It is vitally important that satisfactory replacements be found if the welfare of patients is not to be placed in jeopardy by exposure to unqualified personnel, and if operating suites in hospitals are to operate at full capacity.

There is too much at stake to permit the introduction of untrained people into the operating team with the expectation that they can be adequately trained on the job. A basic course of education and indoctrination must be completed before these aides, recruited from outside sources, can be trusted in the aseptic environment of the operating room. The military services have amply demonstrated that personnel drawn from civilian occupations can be trained by the nursing corps of the services to become thoroughly adequate and trustworthy operating room technicians. Many surgeons became aware of this during World War II and in Korea, and began to question why the lesson might not be applied to peacetime civilian hospitals. There was need for specifications for such training, position openings in this category, and a national sponsoring body.

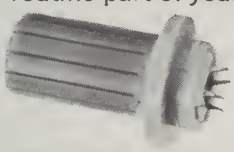
A committee of the Board of Governors of the American College of Surgeons devoted much time and study to this problem from 1962 to 1965. From the outset they were aware that the leadership and the actual instruction of these technicians must be assumed by professional nurses. There was initially an unfortunate misunderstanding that surgeons were intruding into the nurses' sphere. The Association of Operating Room Nurses, however, accepted the challenge and at the end of 1967 produced an excellent training manual entitled "Teaching the Operating Room Technician."

In the meantime, even in the absence of a standardized curriculum, training courses had been developed in various areas under the auspices of individual hospitals, often in collaboration with a nearby junior college giving academic credits. The quality of these courses is still uneven and there is, at present, no good way of evaluating the training and experience of an operating room technician who may have been trained elsewhere. The AORN is presently attempting to rectify this situation. It is giving support and guidance to an organization known as the Association of Operating Room Technicians (AORT) whose members qualify by examination or training in meeting the standards of the AORN. (There are other organizations of surgical technicians which do not have this endorsement.)

Copies of the manual "Teaching the Operating Room Technician," and lists of training programs meeting its standards, may be obtained from the Educational Director, Association of Operating Room Nurses, 575 Madison Avenue, New York, N.Y. 10022. Fellows of the ACS are urged to give their support to this commendable undertaking.

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

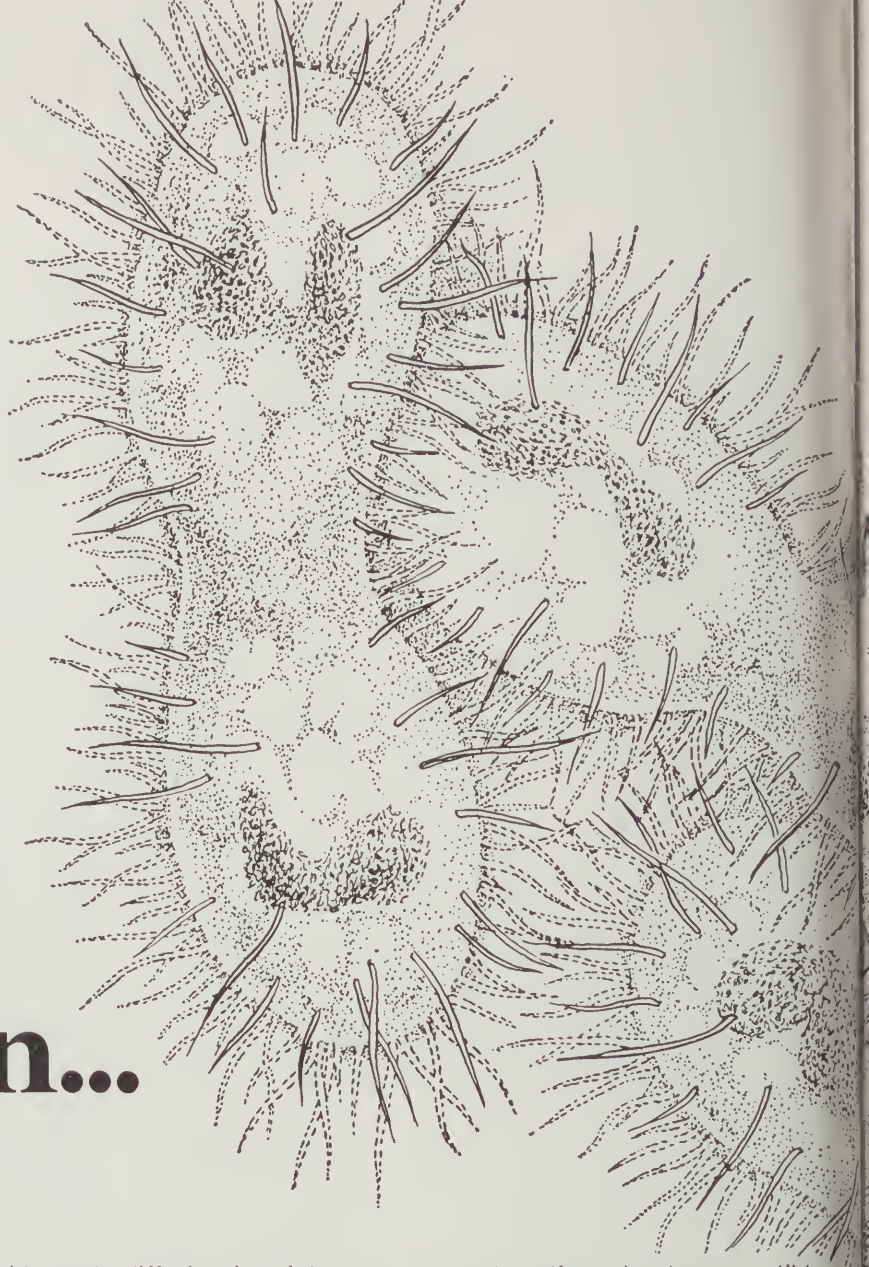
EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





A high index of suspicion... E. coli

How high is the "index of suspicion" for *E. coli* in urinary tract infections?

Recently it has been estimated that about 86 per cent of positive cultures in first attacks of urinary tract infection are *E. coli*.[1] It has also been noted that "The coliform group, especially *E. coli*, accounts for approximately 90 per cent of initial infections...."[2]

Consider wide-spectrum Gantanol® (sulfamethoxazole) for its high "index of confidence"—its proven effectiveness against *E. coli* and other sensitive gram-negative and gram-positive organisms. Therapeutic levels of Gantanol in blood and urine are achieved within 2 hours after a 2-Gm starting dose, with ready diffusion into interstitial fluids. Responsive infections generally clear within 5 to 7 days, with relief of symptoms usually seen within 24-48 hours.

Gantanol also earns its high "index of confidence" because Gantanol therapy is relatively free from complications, including the problem of bacterial resistance or superinfection.

Convenient, economical dosage schedule: *b.i.d.*

References: 1. Vernier, R. L., in Patient Care Feature: *Patient Care, 1*:20 (Feb.) 1967. **2.** Beeson, P. B.: "The Infectious Diseases," in Beeson, P. B., and McDermott, W. (eds.): *Cecil-Loeb Textbook of Medicine*, ed. 12, Philadelphia, W. B. Saunders Company, 1967, p. 230.

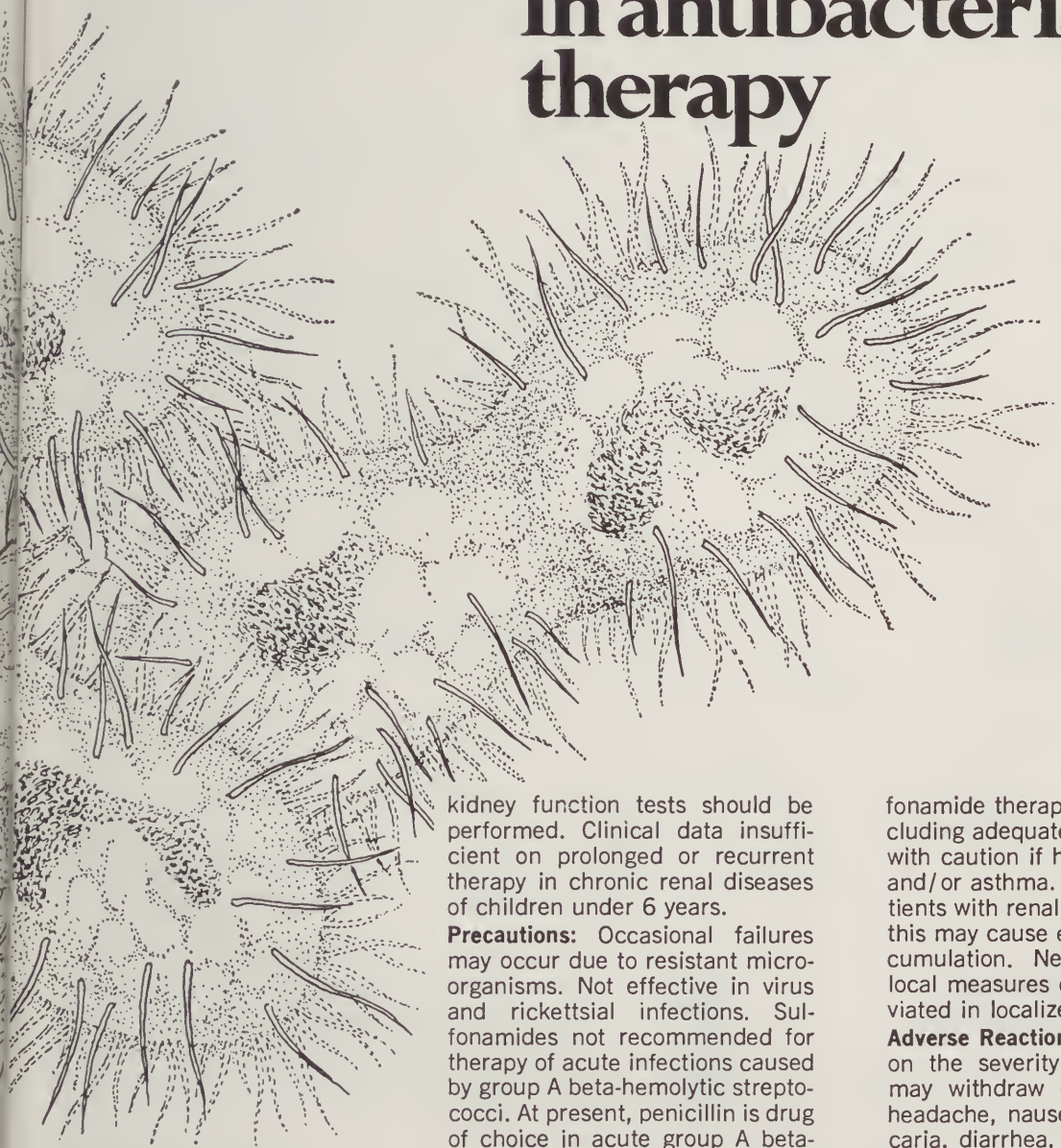
Before prescribing, please consult complete product information, a summary of which follows:

Indications: Acute and chronic urinary tract, respiratory and soft tissue infections due to susceptible microorganisms; prophylactically following diagnostic instrumental procedures on genitourinary tract.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, or newborn infants during first 3 months of life.

Warnings: Use only after critical appraisal in patients with liver or renal damage, urinary obstruction or blood dyscrasias. Deaths reported from hypersensitivity reactions, Stevens-Johnson syndrome, agranulocytosis, aplastic anemia and other blood dyscrasias. In closely intermittent or prolonged therapy, blood counts and liver and

For a high index of confidence... Gantanol® (sulfamethoxazole) in antibacterial therapy



Artist's rendition of E. coli. As with most strains of E. coli, these have flagella and are motile.

kidney function tests should be performed. Clinical data insufficient on prolonged or recurrent therapy in chronic renal diseases of children under 6 years.

Precautions: Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections. Sulfonamides not recommended for therapy of acute infections caused by group A beta-hemolytic streptococci. At present, penicillin is drug of choice in acute group A beta-hemolytic streptococcal infections; although Gantanol has produced favorable bacteriologic conversion rates in this infection, data insufficient on long-term follow-up studies as to its effect on sequelae of rheumatic fever or acute glomerulonephritis. If other treatment cannot be used and Gantanol is employed in such infections, *important that therapy be continued in usual recommended dosage for at least 10 days.* Observe usual sulfonamide therapy precautions, including adequate fluid intake. Use with caution if history of allergies and/or asthma. Follow closely patients with renal impairment since this may cause excessive drug accumulation. Need for indicated local measures or surgery not obviated in localized infections.

Adverse Reactions: Depending upon the severity of the reaction, may withdraw drug in event of headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, Stevens-Johnson syndrome, skin rash, injection of the conjunctiva and sclera, petechiae, purpura, hematuria and crystalluria.

ROCHE

Roche LABORATORIES

Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Classified Advertising

POSITIONS AVAILABLE

PHYSICIAN FOR INDUSTRIAL CLINIC—July 1, 1969 or sooner. Excel. opp. Starting salary $22,000. Profit-sharing plan after 1st yr. Partnership if desired. Contact: Maxwell Hurston, MD, 919 18th St., NW, Washington, D.C. 20006.

GP PARTNERSHIP—Percentage or salary. Retiring in 2-3 years. Two-man office. Not doing hospital work, but open staff hospitals available. Good country. Congenial people. Professional and personal data requested. Send reply to: Box # 9, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

POSITION WANTED

LICENSED PHYSICIAN—Moving to Montgomery Co. in July. Desires evening or weekend work in general practice. Inquiries invited. Box 3317, Duke Hospital, Durham, N.C. 27706

FOR SALE

AIR CONDITIONERS—Almost new, 4, different sizes, reasonable. Write: Box #12, c/o JOURNAL, 1211 Cathedral St, Balto., Md. 21201.

PHYSICIAN'S HOME & OFFICE—Two buildings of stone construction with slate roofs. Each building individually maintained with central heating and a/c. Two bedroom home. Office has large waiting room, 2 exam-consultation rooms, 2 bathrooms. Buildings connected by a breezeway and porch, enclosure—could be converted for other uses. Structures occupy one acre, center of a block on Liberty Rd, near Beltway Exit 18. Call: 653-6565 anytime.

MEDICAL EQUIPMENT—Diathermies, ultra, violet, filing cabinet, desk and chair, operating table, scales, floor magnifying lamp, instruments, other. Owner selling. Call: 1-725-8135 eves.

HOME/OFFICE COMBINATION AND PRACTICE—Well-established practice for internist or general practitioner. Office suite on ground level consists of 5 large rooms, fully air-conditioned. Main floor has 4 large rooms, plus powder room, kitchen and laundry room. Six bedrooms, 2 full bathrooms on second floor. Third floor has 2 spacious bedrooms and powder room. Excellent condition. Reply: Box #14, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

LDG
LUCAS DESIGN GROUP



Contract Interior Design Division of Lucas Bros., Inc.
221 East Baltimore St. ■ MU 5-3000

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

CLASSIFIED ADVERTISING

Effective May 1, 1963

$1.50 per line per insertion

Count seven average words to each line. Add one line if box number is desired.

Members of the Medical and Chirurgical Faculty shall be entitled to one complimentary insertion in any twelve-month period. Widows of members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment.

MARYLAND STATE MEDICAL JOURNAL
1211 Cathedral St., Baltimore, Md. 21201

Advertisers in This Issue

A & F Nurses Registry 5
Aids for Hearing 34
Al-Lin Ambulance Service 130
Arundel Federal Savings & Loan Assoc. 121
Baltimore Nurses Exchange 14
Baltimore Oxygen Supply Co., Inc. 44
Belvedere Hotel 130
Bolton Hill Dinner Theatre 131
Bristol Laboratories 114
Broadview Restaurant 133
Burroughs Wellcome & Co., Inc. 123
Harry T. Campbell & Sons Corp. 46
Capital Savings & Loan Assoc. 148
Oscar Caplan & Sons 8
Chase Waterproofing Co. 48
Chernock Moving & Storage 16
Chesapeake Federal Savings & Loan 116
Club Venus 133
Cobb-Woods Services 136
Cork 'n Bottle Restaurant 133
Dobbs House Restaurant 133
Doctors Supply Co. 13
Eleven East Chase Street Corp. 122
E. C. Ernst, Inc. 48
Evangelical Press 121
Fedder's Medical Services 8
Federated Business Services, Inc. 15
Fields Pharmacy 136
Food & Drug Administration 131
Franklin Uniform Co. 44
Geigy Pharmaceuticals 134-135, 140-142
Globetrotter Travel Services 118
Greenberry Woods 32
Greenfeld Supply Co. 48
The Hecht Co. Northwood, Rooftop Restaurant .. 133
High Fidelity House 18
Highland Hospital 110
Hilton Nursing Home ..... 3rd Cover
Hood Convalescent Home 13
House in the Pines Nursing Homes 59
Hynson, Westcott & Dunning, Inc. 1
Charlie Irish Chevrolet Co. 46
Jewett Refrigerator 46
Henry A. Knott, Inc. 47
Lederle Laboratories 2, 21, 30, 34, 116, 136, 143
Eli Lily & Co. 4
Lucas Brothers 148
Maico Hearing Aids, Inc. 116
Maria's 300 Restaurant 133
Maryland Volkswagen 122
Mckee-Berger-Monsueto, Inc. 45
Mercantile-Safe Deposit & Trust Co. 17
Merck, Sharp & Dohme 127-128
Miller Brothers Restaurant 133
Milton Inn 133
Monarch Lincoln Mercury, Inc. 116
Murray-Baumgartner Surg. Instr. Co., Inc. 11
Nelco Corporation 54
Palmer House Restaurant 133
Parke, Davis & Co. 19, 55
Chas. Pfizer & Co., Inc., Pfizer Laboratories Division, Bonine 26-27
Pitman-Moore 22-23
Pleasant Manor Nurs. & Conv. Home 121
T. Rowe Price Growth Stock Fund, Inc. 30
Professional Management Co. 11
Professional Systems & Services 12
Puritan-Bennett Corp. 48
Geo. Radebaugh & Sons 14
Read's Drug Stores 18
R & H Motors, Inc. 136
A. H. Robins Co. 112-113, 126
Roche Laboratories ..... 124-125, 146-147, 4th Cover
Russell, Marsh & Kennedy, Inc. 130
Sakura Palace 18
Manuel Schwartz 118
G. D. Searle & Co. 56-57
Myrtle Seidel Antiques 130
Skill Surgical Instrument Co. 130
Smith Kline & French Laboratories 28
Special Diet Shop 5
Sterling Lighting Co. 136
Stuart 20
Mano Swartz—Furs 8
Taylor Manor Hospital ..... 2nd Cover
Therapeutic Appliances, Inc. 18
Tijuana Tacos 133
Town & Country Motors 122
Twentieth Century Auto Radio & TV 111
Union Trust Company of Md. 6
Van Dyke & Bacon Shoes 34
Ventnor Marine Service 122
Walbrook Mill & Lumber Co. 48
D. Stuart Webb Advertising Services, Inc. 15
Westview Lounge & Supper Club 133
White Rice Inn 133
Winthrop Laboratories 58
Wyeth Laboratories 144-145
Zimmerman's Shoes 8

Schools teach your kids how to read and write.

We teach them how to save lives.



help us help

The American Red Cross.
We don't know where
we'll be needed next.

You don't either.

advertising contributed for the public good

ADVERTISING COUNCIL

Opening 1969



HILTON NURSING HOME

3313 Poplar Street, corner of Hilton

4 blocks south of North Ave. & Hilton St.

BALTIMORE

Now being built—a superb new 104-bed facility, the last word in pleasant living and competent care for the aged, ill or convalescent. Embodying the highest standards and the most advanced equipment and luxurious furnishings, it will meet your most exacting requirements.

Modern, air-conditioned and fire-safe building

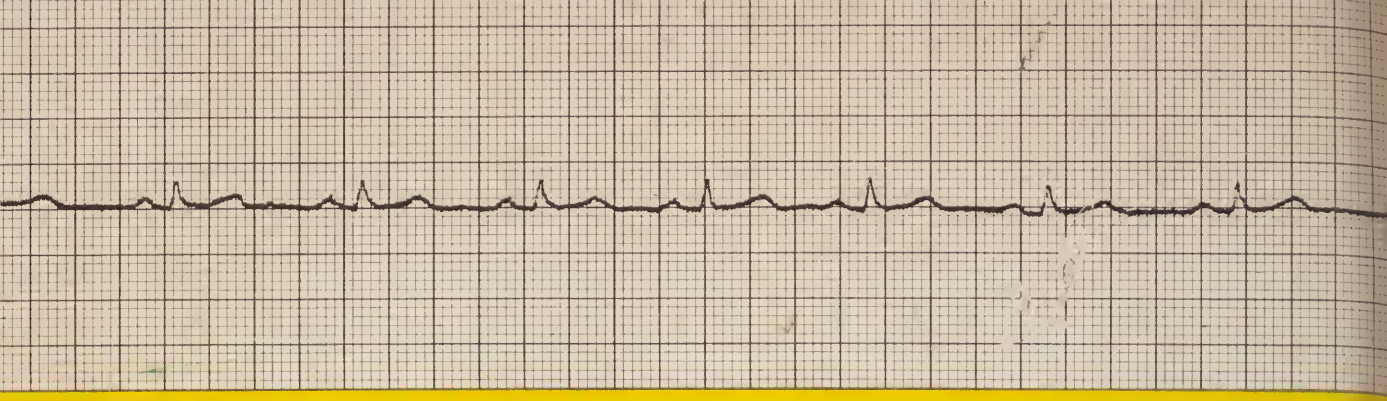
Finest facilities for comfort and health care

104 beds, all in private and semi-private rooms—no wards or dormitories

Registered nurses 24 hours a day

For advance information . . . . phone

426-3104



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

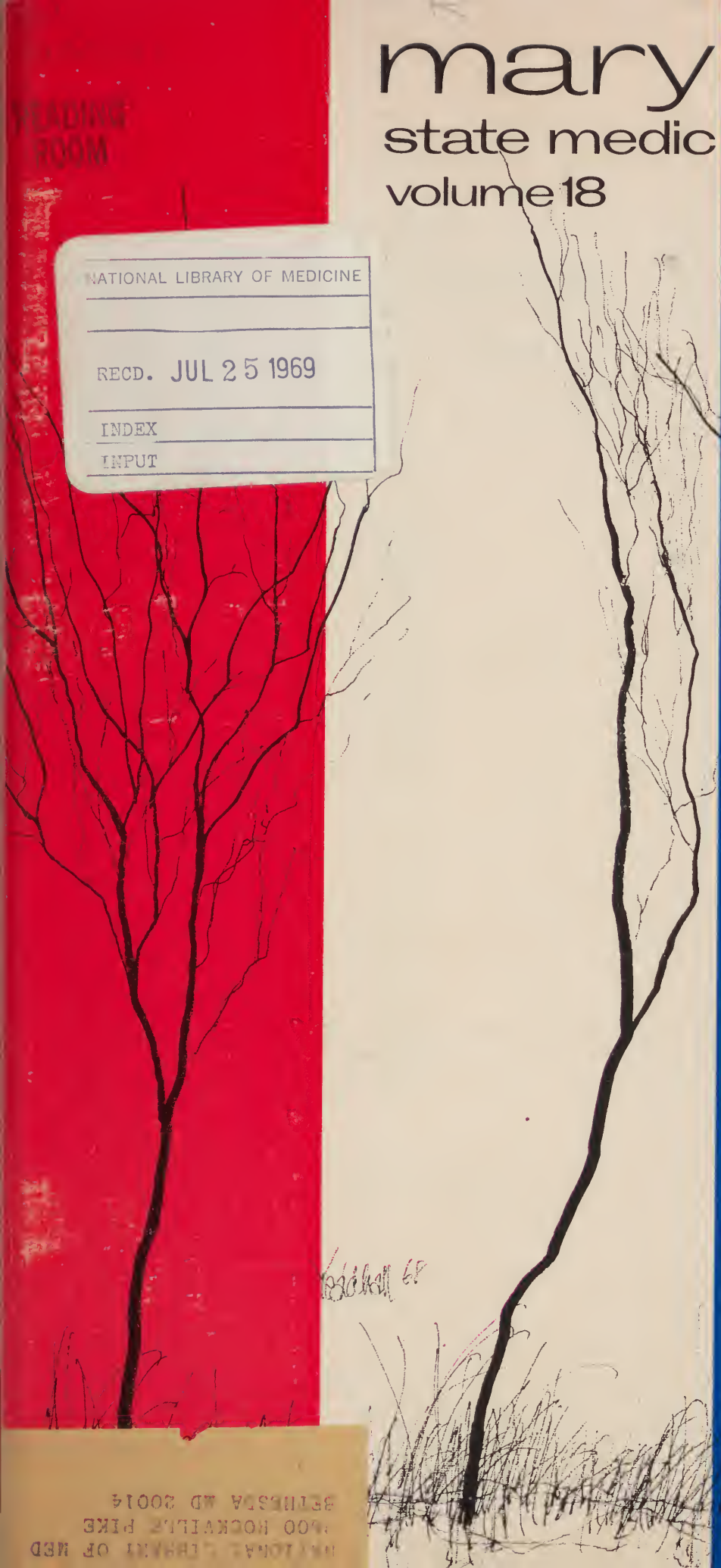
READING ROOM

maryland state medical journal

volume 18
number 7
July 1969

NATIONAL LIBRARY OF MEDICINE
RECD. JUL 25 1969
INDEX
INPUT

JTC: LJY
INDEXER:
VOL-ISS: 18-7
DATE:
DEPTH:
NON-DEPTH:
RUSH:
SELECTIVE:



NATIONAL LIBRARY OF MED
8600 ROCKVILLE PIKE
BETHESDA MD 20014

How much does illness and lost time cost you?

KEX FLOOR PLAN PACKAGE —SERVICED BY RENTEX— IS EFFECTIVE AGAINST INFECTIOUS GERMS!

Read this Important News Now: — The U.S. Dept. of Agriculture has accepted the following claims for KEX Services:

- "KEX" Walk-Off-Mats are chemically treated with an anti-microbial additive to inhibit the growth and spread of environmental bacteria in a mat and to reduce contamination in the areas serviced by Walk-Off-Mats.
- "KEX" Walk-Off-Mats are effective against Staph Aureus.
- "KEX" Walk-Off-Mats reduce populations of air and dust-borne Staph Aureus in the areas serviced by Walk-Off-Mats.
- "KEX" Walk-Off-Mats reduce the introduction of bacterial populations in rooms serviced by Walk-Off-Mats.

Help clean the air for you and your employees. Let your Rentex Service expert show you how to minimize air borne bacteria with KEX Services. Act Now — TODAY! Call CE. 3-5700.

RENTEX SERVICES CORP.

RENTEX EASTERN OVERALL DIVISION

2804 WILKENS AVE., BALTIMORE, MD. 21223 • CE 3-5700

EASTON, MARYLAND ALEXANDRIA, VA.

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.

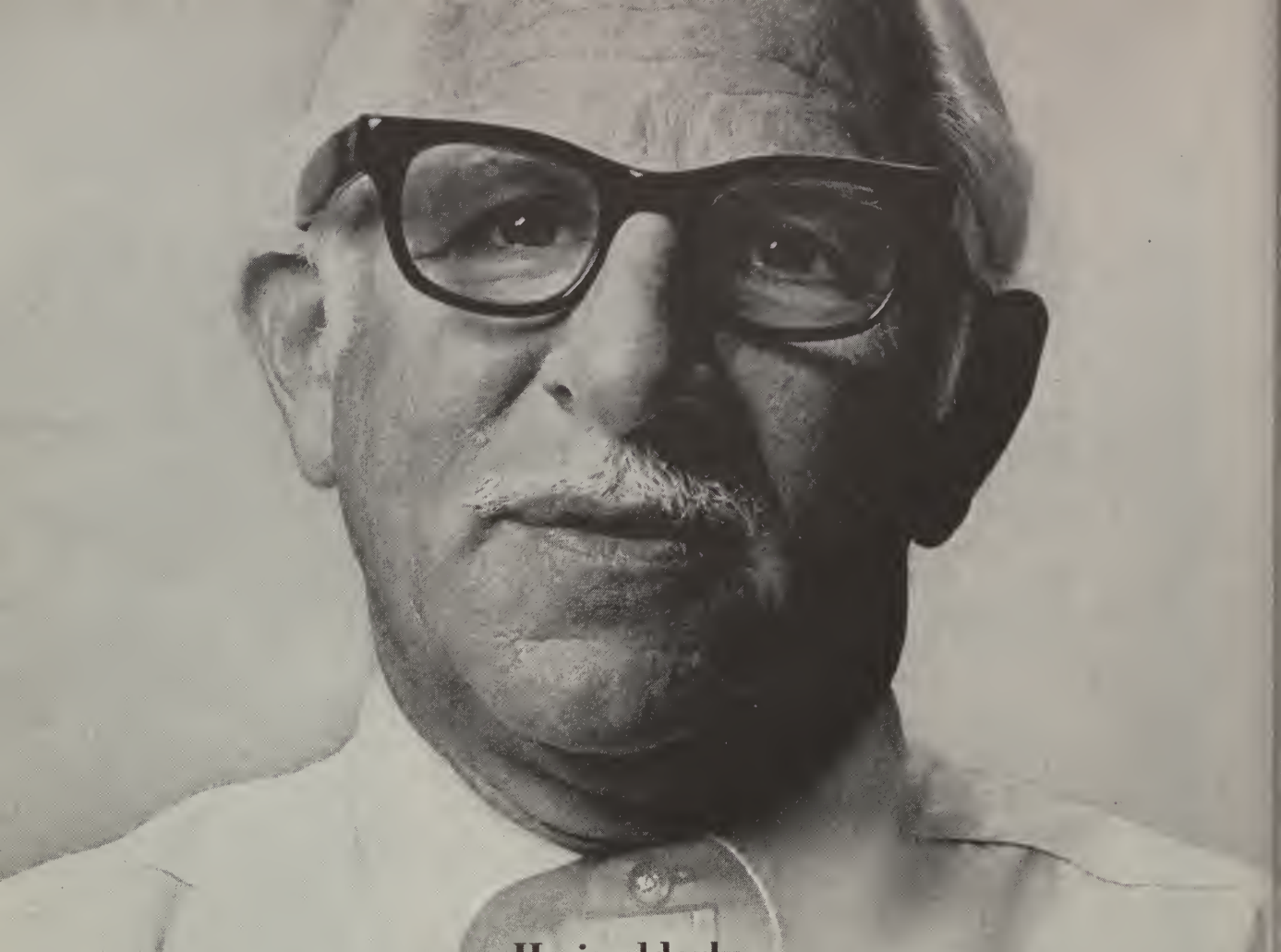
HWD

Baltimore, Maryland 21201

(LX-05)

LX
LX
LX

References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

345-8

Maryland State Medical Journal

VOLUME 18 JULY 1969 NUMBER 7

CONTENTS:

What is a Psychiatrist? Walter Weintraub, MD 75

"In attempting to describe the responsibilities and areas of competence of the psychiatrist, one is tempted to simplify the task by creating the best possible image for the profession, and by avoiding controversial issues. To do so, however, would not only be an insult to the intelligence of a sophisticated audience, but would hardly advance the purposes of promoting interdisciplinary relationships."

Clergy-Physician Dialogues 77

"The particular interest and value of these discussions is that they come out of the experience of clergymen and physicians dealing with patients daily. The problems encountered are concrete, immediate, and very real to those involved. There is a determination to make Christian concern relevant to the lives of suffering people in hospitals."

Annual Financial Report 47

DEPARTMENTS:

Traffic Safety—Does Your Patient Have Periods of Unconsciousness or Amnesia? Ruth W. Baldwin, MD 65

Your Medical Faculty at Work, John Sargeant 85

Heart Page—Artificial Cardiac Pacing—Current Status, Miriam L. Cohen, MD, and Richard D. Biggs, Jr., MD 87

Maryland State Department of Health—Comparative Price List: Generic vs Brand Name Drugs 89

Maryland State Department of Mental Hygiene—On Baltimore's Mental Health Problems and Needs 93

Alcoholism—The Alcoholic in the Emergency Room, Richard D. Anderson, MD, and Maxwell N. Weisman, MD 101

Pathology—Renal Biopsy, Robert H. Heptinstall, MD 105

Library Page—Advances in Medical Libraries 107

Rehabilitation Notes—Rehabilitation of Patients Suffering from Fracture of the Hip, Part I, John D. Hsu, MD 111

Tuberculosis—Childhood Sarcoidosis 117

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland.

Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EDITORIAL ASSISTANT
Elizabeth Sinnott

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

ON THE COVER: In the spirit of Independence Day we have selected an original painting by **Robert Yealdhall,** a Baltimore artist. The JOURNAL staff offers no aesthetic interpretation except to say that if we don't start looking after our nation a bit better, the United States will begin to resemble the tree on the far-right panel—sparse, bare, broken, and devoid of life. The painting is from the collection of **Mr. and Mrs. John Sargeant.**

Doctors Take Note—Med-Chi Semiannual Meeting **5**
Application Form for Scientific Exhibits **13**
Booklet on Drug Abuse **18**
Pharmacy School Shows Dangers of Drug Abuse **26**
The Month in Washington **27**
Leukemias, Lymphomas and Myelomas **31**
Component Societies **35**
Medical News **68**
Highlights of Annual Meeting in April **73**
Library Accessions **107**
New Professional Practitioner: The Pediatric Associate **115**
Resort Index **122**
Wide Foundation for Specialists **130**
Blue Shield's Future Role in Title 19 **134**
Did You Know? **135**
Classified Advertising **136**
Advertising Index **137**
Information for Authors **138**


Lilly
H06
Darvon®
Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.
900252

Doctors take note...

IMPORTANT DATES

THURSDAY, FRIDAY, SATURDAY, SEPTEMBER 4, 5, 6, 1969

SEMIANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

at the

HOTEL HERSHEY, HERSHEY, PENNSYLVANIA

The Semiannual Meeting in Hershey has been geared to many scientific and social functions:

Thursday, September 4

Executive Committee and Council Meetings

Fun for all—MONTE CARLO NIGHT—For physicians, their wives and guests

Friday, September 5

MEETINGS: House of Delegates
Woman's Auxiliary

Scientific program on "DRUG ABUSE—SOME ALTERNATIVES"
(Of interest to physicians, their wives and guests)

MMPAC Luncheon (Maryland Medical Political Action Committee)—"WHAT'S IT ALL ABOUT?"

Cocktail Party and Semiannual Banquet

TOURS: Hershey Medical Center (Devoted to the production of Family Physicians)
Chocolate Town and Factory

Saturday, September 6

MEETINGS: College of Surgeons
Diabetes Association
Psychiatric Society
Rheumatic Diseases
Nursing Home Physicians
Board of Directors, Maryland Academy of General Practice

TOURS: Amish Country, including a "Pennsylvania Dutch" lunch

GOLF TOURNAMENT

ENTERTAINMENT—A surprise evening

If your hotel reservation has not been made, fill in the reservation form and mail today. September 4-6 will be a weekend of worthwhile postgraduate education, as well as one of relaxation and fun for all. The complete program will be mailed the first week in August to all members, and to others upon request.

DeWitt E. DeLawter, MD, Chairman
Committee on Program and Arrangements

For reservation form, see next page.

AUGUST 14-15, 1969
GERMANTOWN ACADEMY

3rd Annual Germantown Academy Symposium on Sports Medicine: Academy's Fort Washington, Pa. campus. The symposium is designed for and open to physicians, nurses, trainers, coaches, administrators, and all others interested or involved in school medicine, sports, and conditioning. Frank J. Tornetta, MD, president of the Montgomery County Medical Association, will deliver a welcoming address. For further information, contact: William R. Talbot, Jr., Tel. MI 6-3300, Ext 34 (Fort Washington, Pa.)

SEPTEMBER 25-27, 1969
CHICAGO COMMITTEE ON TRAUMA/AMERICAN COLLEGE OF SURGEONS

3rd Annual Postgraduate Course for Emergency Room Nurses: Palmer House Hotel, Chicago. Advance registration is required and should be accompanied by the tuition fee of $60, which covers three full days of scientific sessions and the chairman's reception and banquet. Address registration fees and inquiries to: George T. Anast, MD, Chairman, 55 East Washington St., Chicago, Ill. 60602.

Medical and Chirurgical Faculty of Maryland

HOTEL HERSHEY

September 4, 5, 6, 1969

PLEASE CHECK THE APPROPRIATE SPACES AND RETURN PROMPTLY TO:

Mr. Harvey S. Schell, Reservations Manager
Hotel Hershey, Hershey, Pennsylvania 17033

ROOM RATES: AMERICAN PLAN, WITH MEALS

Twin-bedded rooms .....$24.00 per person per day—2 in a room

Single rooms .....$27.00 per person per day

(A 15% Gratuity to be added to the above rates. This takes care of the Dining Room Personnel on food only, bellmen for check in and out, maids and doormen. Individuals to do other tipping on their own, such as room service, beverage bills, etc.)

PLEASE RESERVE THE FOLLOWING ACCOMMODATIONS:

.....Twin bedded rooms

.....Single rooms

.....
NAME OF MEMBER SHARING ROOM

ARRIVAL DATE..... DEPARTURE DATE.....
(ROOMS NOT AVAILABLE UNTIL 4:00 P.M.) (1:00 P.M. CHECK OUT TIME)

.....
DATE



1 out of 3 Marylanders belongs to BLUE SHIELD®

Today more than one million Marylanders are Blue Shield members. Last year alone, they received more than $20 million in medical and surgical care benefits. And since there are more than four thousand Maryland groups now offering this form of coverage to their employees, there must be a good reason—or reasons—for the preference for Blue Shield.

One very important reason is the unselfish devotion of you and your colleagues to the Blue Shield concept.

To find out more about Blue Shield, just use the convenient coupon.

Maryland Blue Shield®

7800 York Road
Baltimore, Maryland 21203

Please send me my free copy of your booklet on Blue Shield.

Name_____

Address_____

City_____ State_____ Zip_____

Inexpensive
Effective



HEAD HALTER TRACTOR KIT

Recommended for traction treatment of:

1. Syndromes caused by slipped cervical discs.
2. Certain fractures of cervical vertebrae.
3. Certain types of tuberculosis of the spine, in preparation for, instead of or after fusion of the spine.
4. Certain cases of neck-muscle spasm.
5. Temporary measure until a cervical brace is prepared.

DONALD O. FEDDER, ORTHOTIST

Rents and Sells
Hospital Equipment

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

We Buy
Estate Jewelry

We purchase jewelry, precious stones and heirloom jewelry from private owners, estates, family collections, etc., for immediate cash.

Recently we have acquired some choice pieces which we offer for sale at prices far below replacement value.

Inquiries invited whether selling or buying.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

Specializing in the
fitting of shoes
for proper foot function
and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday
and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.

ADVANCE FUR SALE!

- **Take your selection home for three days to inspect it and make your decision.**
- **When you have confirmed your selection we will store your fur free of charge.**
- **Your decision need not be final until you take your fur out of storage.**

Your purchase MUST BE completely satisfactory

Maryland's Exclusive Representative for

Oleg Cassini
FURS

Mano Swartz

225 N. Howard St.
Baltimore, Md. 21201



LE 9-4900

executive secretary's newsletter

July, 1969

DATES TO REMEMBER

Deadline for Resolutions for Semiannual Meeting:

FRIDAY, JULY 11, 1969

Reference Committee Hearing (for resolutions up for consideration at the Semiannual Meeting):

Thursday, August 14, 1969, 7:30 p.m.

Semiannual Meeting, Hershey, Pa., September 4, 5, 6, 1969

Charter trip to Spain, October 12-21, 1969 (tentative)

Annual Meeting, Baltimore, Md., April 1, 2, 3, 1970

Charter trip to the Far East, May 1, 1970 (14 days)

REPORTS IN THE WORKS

In the near future, look for reports from the Faculty on Drug Addiction... Multiphasic Screening...Admission policies for Coronary Care and Intensive Care Units... Legal rulings on Consent Forms...and Medical Care for the Emancipated Minor.

All of these and more are under study within Faculty ad hoc groups working towards solutions of these problems.

STANDARDS FOR RENAL DIALYSIS AND TRANSPLANT

A recently appointed Ad Hoc Committee is developing Standards for Renal Dialysis and Transplantation and is anxious to hear the views of interested parties.

The group is planning to develop guidelines for medical ethics in this field as well. Also included will be consideration of locations for centers throughout the State where such Dialysis and Transplantation can best be performed.

Let the Faculty office know of your interest in serving with this Committee.

MEDIC IN FIFTH YEAR

On Friday, September 26, 1969, MEDIC will begin its fifth year of operation. Full programs have been developed and are at the printers. The opening session

MEDIC IN FIFTH YEAR (cont'd)

will be on Uses and Abuses of Antibiotics, presented by Patricia Charache, MD, Assistant Professor of Medicine, The Johns Hopkins University School of Medicine, and will originate at Frederick Memorial Hospital, where the system was first initiated.

NEW FACULTY PUBLICATION

In the course of preparation is a booklet which will combine various Faculty opinions, Guidelines, Regulations and Laws of Maryland with which physicians should be familiar; and in some cases, must comply.

Copies will be mailed to all Faculty members when it is available. Additional copies will be available in limited quantities on individual request.

RUBELLA VACCINE

Guidelines for the use of Rubella Vaccine have been jointly developed with the Faculty's Immunization Subcommittee and the State Health Department.

Copies have been mailed to all Faculty members. Physicians are urged to read these principles carefully and evaluate their application to their patients.

HERSHEY MEETING

While the Hershey Hotel is more than half-filled, it is still not too late to make your reservations for a fun-filled weekend at the time of the Semiannual Session.

Reservation blanks for the various activities, including the Golf Tournament for Men and Ladies, will be mailed shortly.

GOVERNOR'S HEALTH CONFERENCE

Russell S. Fisher, MD, Faculty President; John F. Schaefer, MD, Council Chairman; Henry A. Briele, MD President-elect; and Mr. John Sargeant were all in attendance at the Governor's Health Conference held in June.

The first of its kind in Maryland (and we understand in the Nation) prime attention was given to the health manpower shortage and methods of delivery of health care services.

It was chaired by the newly appointed Secretary of Health and Mental Hygiene, Neil Solomon, MD.

John Sargeant

Executive Secretary

YOU CAN BE SURE

DOCTOR

YOUR SYSTEM ALSO NEEDS
PERIODIC CHECK-UPS . . .
IMPROVED ROUTINES AND
POSITIVE CONTROLS

℞

◆

All change is not progress—but
seldom is progress ever made
without change.

◆

OUR SERVICE
OFFERS YOU

MAXIMUM CONTROL AND SAFETY
FROM BALANCING RECORDS AND
MINIMUM EFFORT ON YOUR PART

◆

FINANCIAL MANAGEMENT
CAN HELP YOU

◆

DIAL 752-5920

Professional Management Co.

914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN

Featherlite
Contour-Shaped
Surgical Two-Way



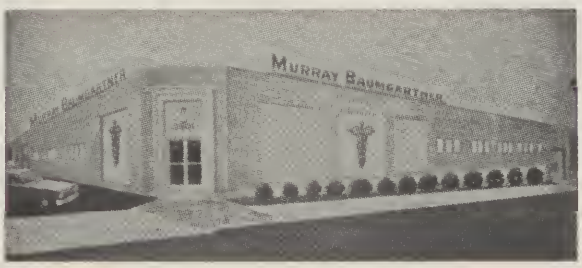
SEAMLESS ELASTIC HOSIERY

Now! . . . a new concept in elastic hosiery achieves excellent cosmetic effect and provides the necessary therapeutic qualities of surgical weight. Using a patented inlay method to insure proper lateral support, fine gauge nylon-covered rubber thread is knitted with MAGILOFT (stretch nylon) yarn to produce a lightweight elastic two-way stretch stocking highly resistant to runs and snags.

For the FIRST time in this field, both STOCK and SPECIALS are available; thus you may offer your patients complete selection of elastic two-way stretch stockings with proper compression, regardless of size or shape.

The Contour-Shape, combined with a MAGILOFT SOFT TOP and knitted-in heel, has eliminated wrinkles at ankle and all tendency to slip down at the top.

The SUPPORT of surgical weight is retained with the advantages of light weight, and all the desirable features of fine gage hosiery.



MURRAY-BAUMGARTNER

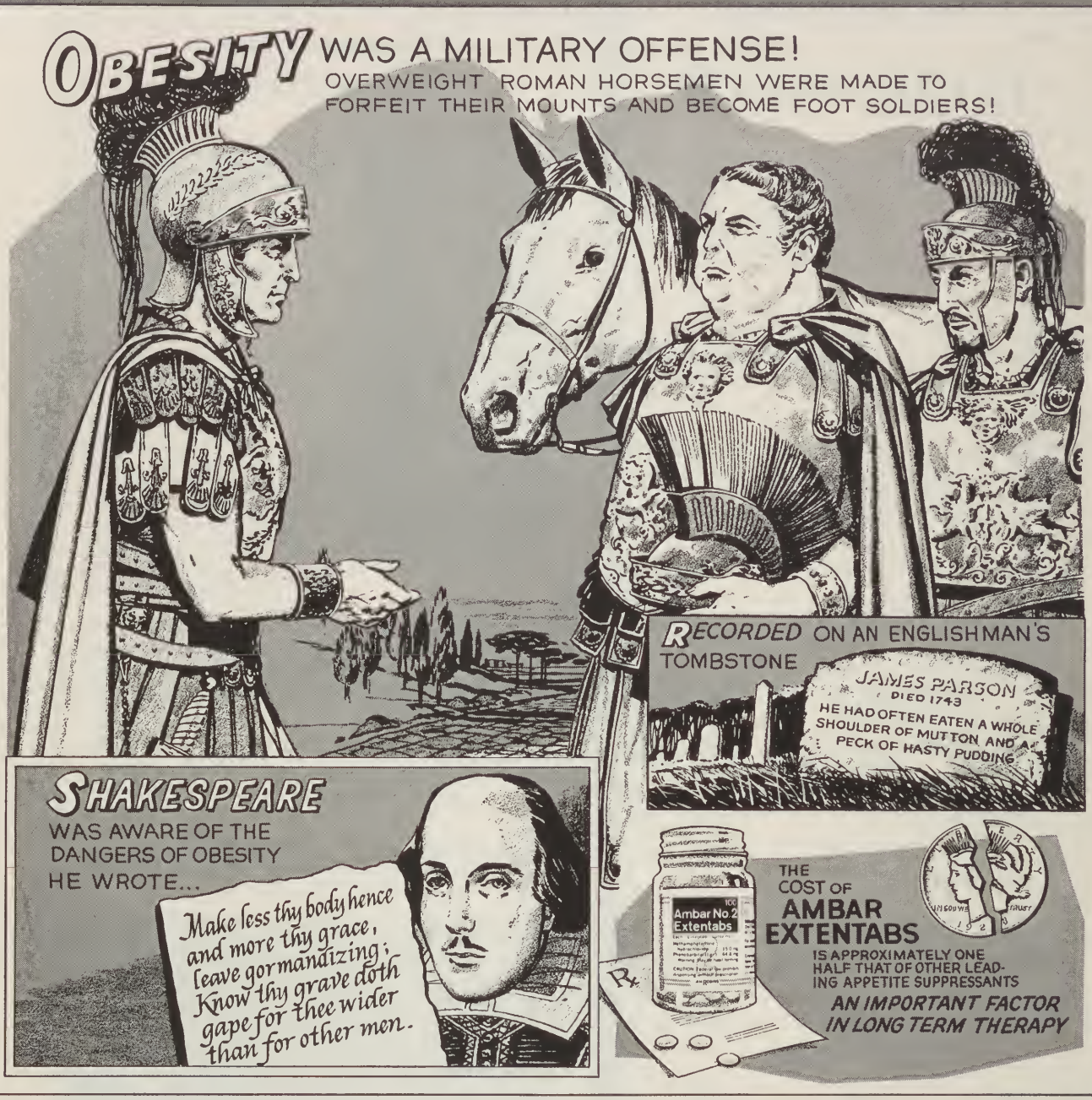
SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.

Phone: 669-9300 **Baltimore, Md. 21216**

Serving the Medical Profession for Almost Half a Century

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

APRIL 1, 2, 3, 1970

The Alcazar, Baltimore

As space is limited, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

7. Name of institution cooperating in the exhibit: _____

_____

8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS

Computer Monitoring of Expectant Mothers

A small computer is now being used in the Lying-In Hospital of the University of Chicago hospitals and clinics in a preliminary study to monitor the condition of expectant mothers where probable complications are indicated.

The computer can maintain a constant vigil over the patient and analyze and display its observations. Subtle patho-physiologic deviations from normal labor can now be more easily interpreted by the obstetrician. The computer, called LINC-8, samples incoming signals from electrodes attached to the patient and produces a visual screen display showing: 1) the uterine pressure curve, 2) a graphic representation of the contraction's normality, 3) the interval between the last two contractions, and 4) the amplitude of the last contraction and the work done by that contraction. The computer display is sent via closed circuit television to the patient's room for the obstetrician to study.



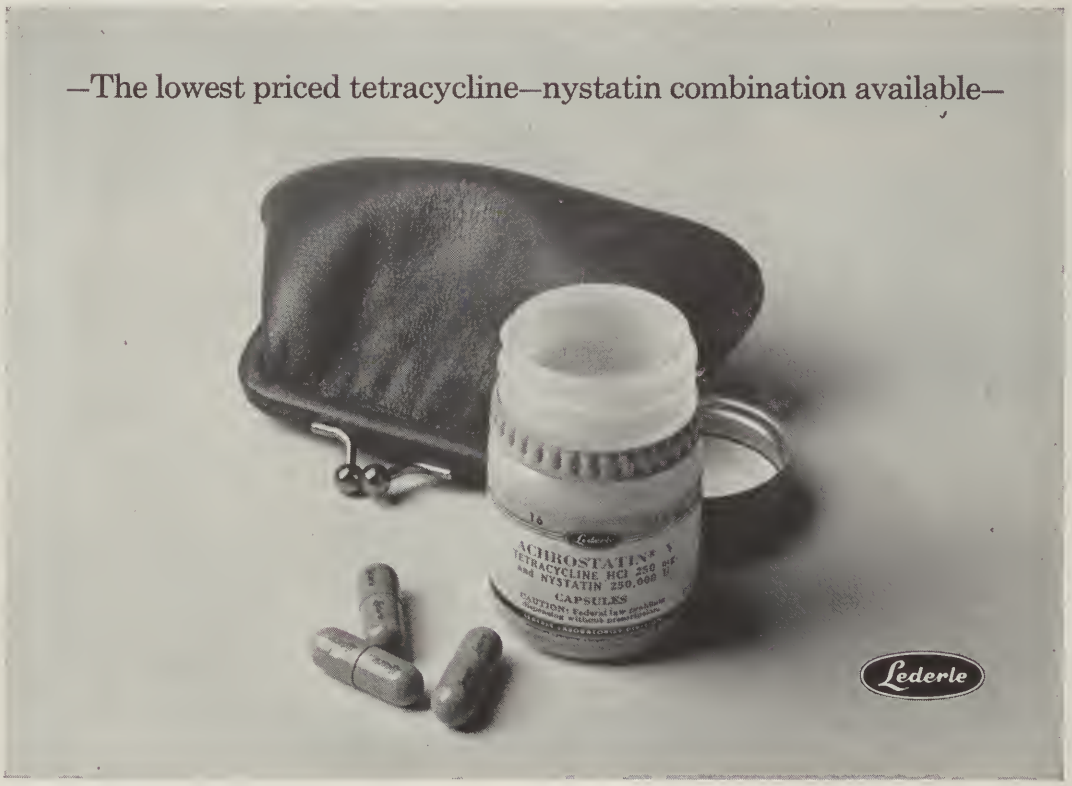
Mercedes-Benz does not make conventional cars... and never will!

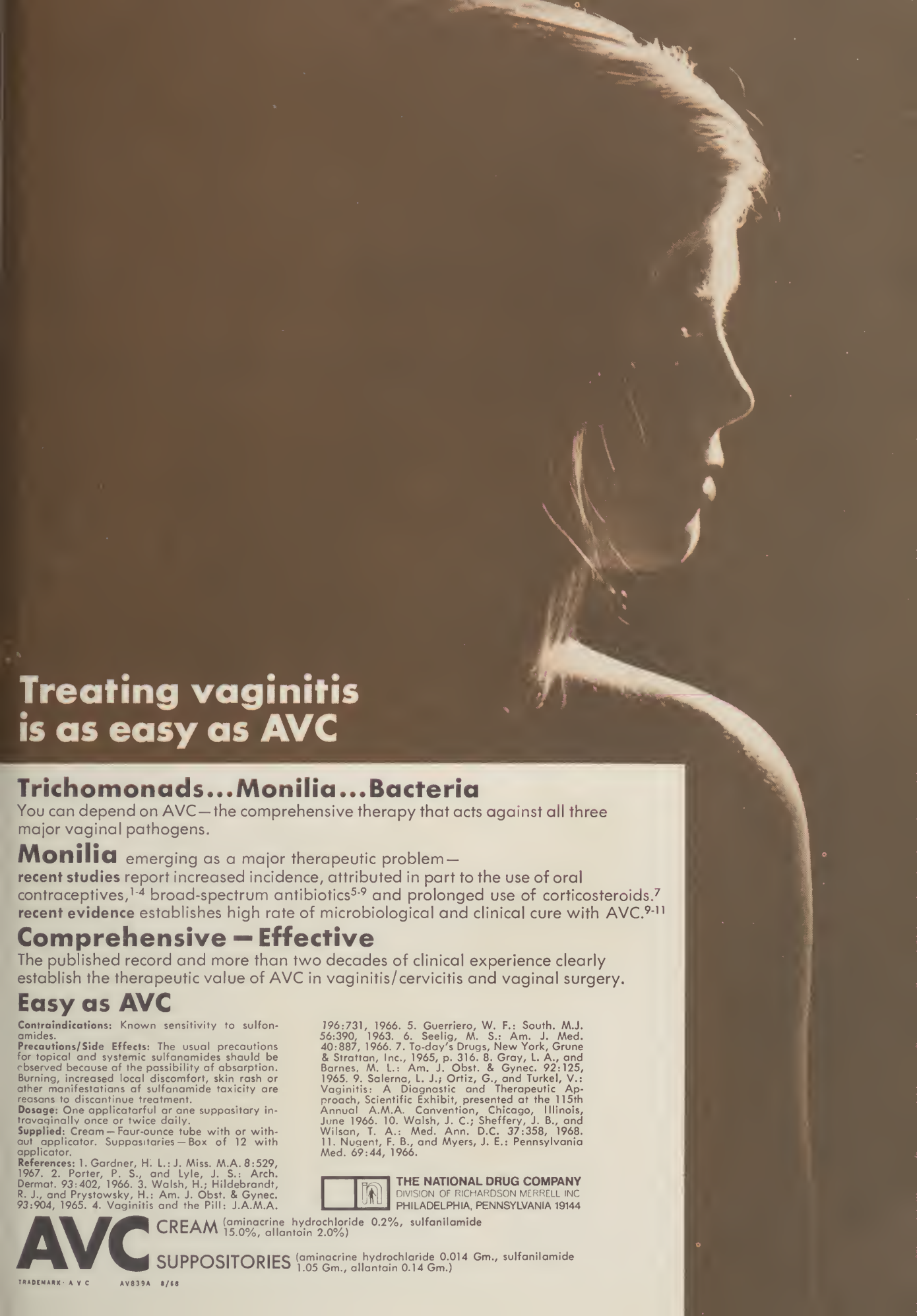
TOWSON VALLEY MOTORS
Mercedes-Benz
103 E. Pennsylvania Ave., Towson (Just behind Hutzler's) 821-8000

BLOOD PLAN
of the
METROPOLITAN WASHINGTON BLOOD BANKS, INC.
Not For Profit
A BLOOD DONATION TODAY PROTECTS YOU AND YOUR FAMILY TOMORROW
- A Medically Supervised Blood Benefit Program
- Individual—Family—Group Memberships

T. A. Loosbrock, Exec. Dir.
915 19th St. N.W., Suite 500 Phone 737-0060
Washington, D.C. 20006

—The lowest priced tetracycline—nystatin combination available—





Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive — Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonamides.
Precautions/Side Effects: The usual precautions for topical and systemic sulfanamides should be observed because of the passibility of absarption. Burning, increased local discomfort, skin rash or other manifestations of sulfanamide toxicity are reasons to discontinue treatment.
Dosage: One applicatarful or one suppasitary intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppasitaries—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-day's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerna, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnastic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Canvention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilsan, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (aminacrine hydrochloride 0.2%, sulfanilamide 15.0%, allantoin 2.0%)

SUPPOSITORIES (aminacrine hydrochlaride 0.014 Gm., sulfanilamide 1.05 Gm., allantain 0.14 Gm.)

TRADEMARK- A V C

AV839A 8/68

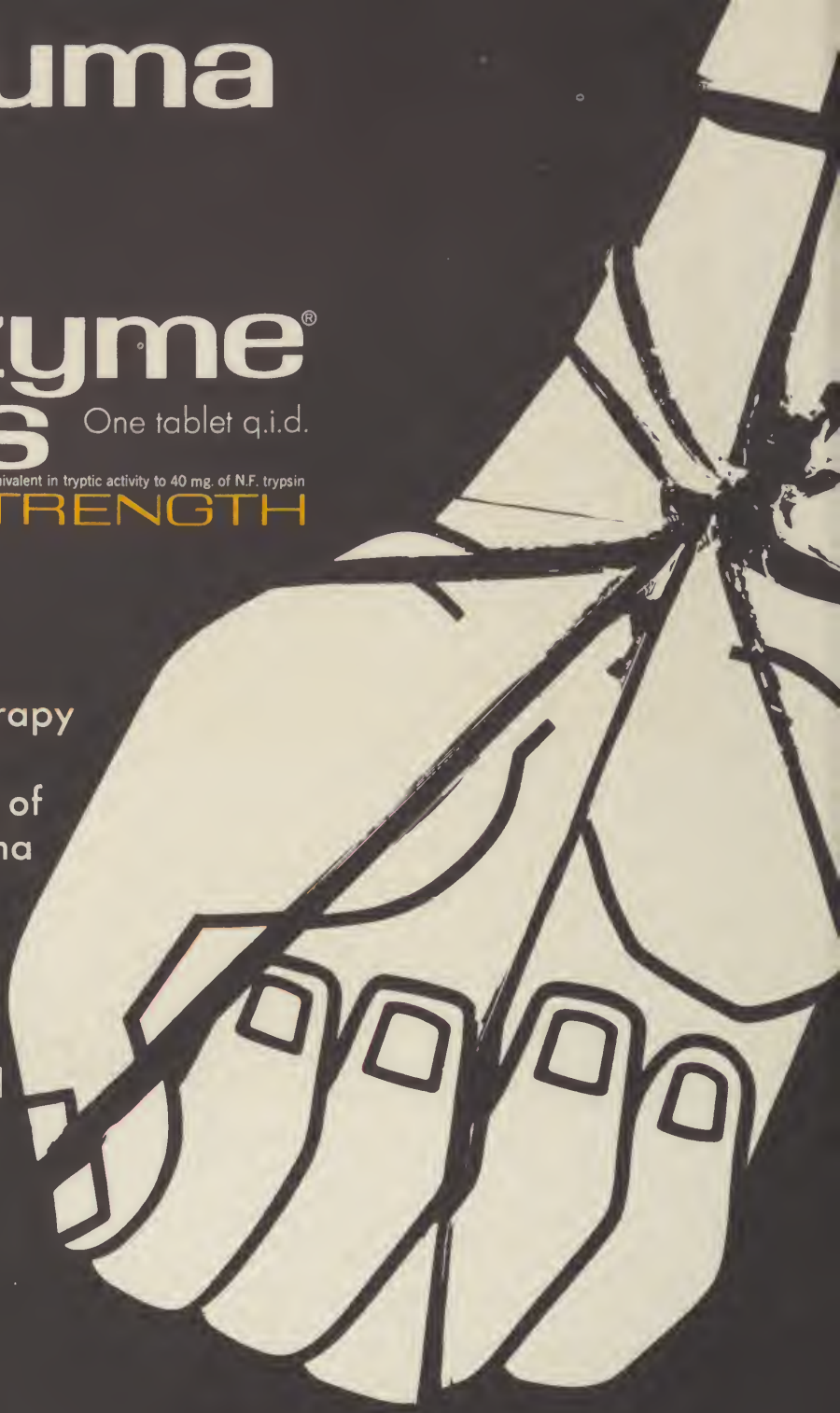
in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.



Description: ORENZYME BITABS offers the theropeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

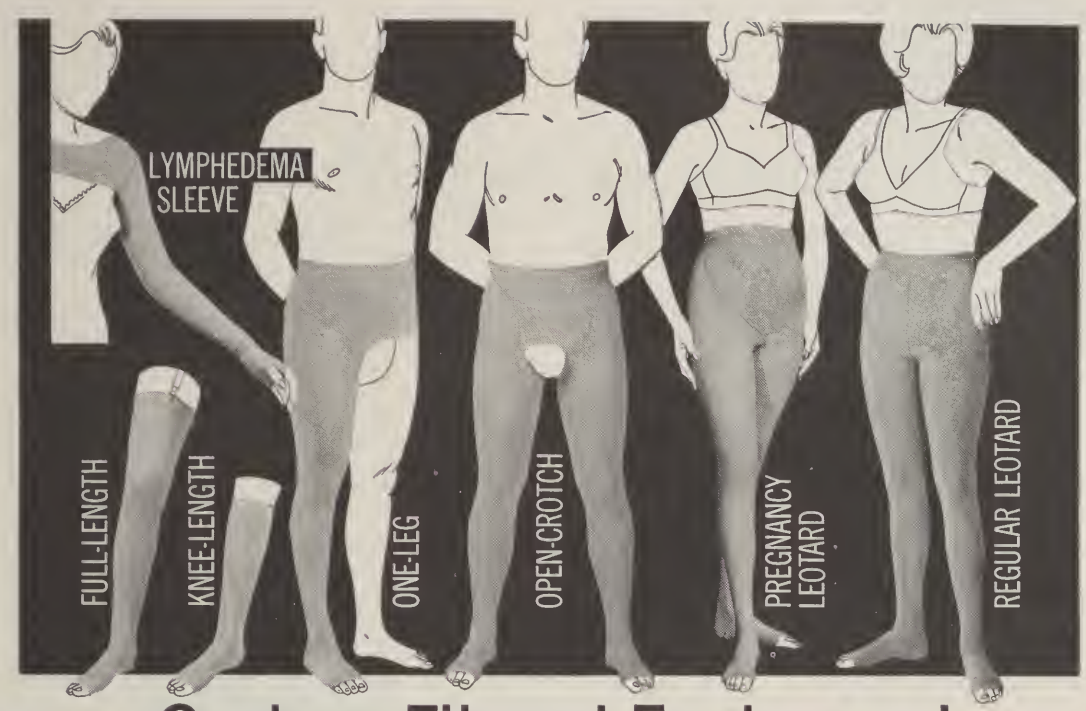
Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A



Custom-Fit, and Engineered For Your Individual Patient

Jobst Venous Pressure Gradient® supports are custom-made and precisely fitted to the contour of the affected extremity of the individual patient in a series of careful measurements.

Even more *important* than the perfect fit, are the exact counterpressures built-in according to your own prescription!

Jobst Venous Pressure Gradient® elastic stockings are a treatment of *choice* for leg ulcers, varicose veins, stasis dermatitis, postmastectomy lymphedema, post-phlebitis syndrome, post-fracture, post-operative and injury edema.

For full information, have your secretary mail the coupon below. Or just call the number shown. You will find out why we named them "Service" Centers.

Jobst Service Center,

Suite 200, 818 Eighteenth Street, N.W.
Washington 20006, Phone (202) 298-5530

Suite 415, Medical Arts Bldg., 101 W. Read St.
Baltimore 21201, Phone (301) 539-0560



NAME _____

INSTITUTION _____

ADDRESS _____

CITY, STATE, ZIP _____

Booklet on Drug Abuse

"In the final analysis, playing games with the truth has historically been demonstrated to be a mistake."

These are the words of a psychologist at the National Institute of Mental Health in Washington, speaking about the need to communicate honestly with young people on the use of drugs. This statement also provides the basis for a 48-page book on drug abuse published by the National Association of Blue Shield Plans. It is offered free by most Blue Shield Plans throughout the United States.

Drug Abuse: The Chemical Cop-Out is primarily aimed at dispelling the romantic illusions of drugs, and separating the facts from the myths for both adults and young people. While authorities generally agree that most people suffer from misinformation, they also concede that parents are perhaps more lacking in knowledge about drugs than their teenagers. John Finlator, associate director of the Federal Bureau of Narcotics and Dangerous Drugs, states, "There is one thing I think we are all missing the boat on. That is, we, who are in authority, find ourselves pretty ignorant about the drug problem around us. The school teacher, the parent, the school administrator, the businessman, and the housewife are all ignorant about the problem. Thus, when a young person starts talking about drugs, neither his parents nor his teachers are really able to keep up with him. If we are going to solve the drug problem, we must do so through an effective educational process, and one that can be accepted."

The four-color booklet features many photographs taken during the filming of three television specials on drug abuse being sponsored on television stations by local Blue Shield Plans. The three films are narrated by Robert Mitchum, Paul Newman, and Rod Steiger respectively.

In addition to providing a comprehensive description of popular drugs being abused, *Chemical Cop-Out* explains many of the physical and psychological effects of such drugs as marijuana, the amphetamines, LSD, mescaline, and others. It also explores some of the sociological and psychological reasons for abusing drugs and how society is reacting to the use of chemicals as a means for escape. In the booklet, Dr. Robert Petersen of the National Institute of Mental Health observes: "Parents are frightened, and you can certainly understand why they are concerned, if for no other reason than they tend to believe the notion that a joint of marijuana is the first step to becoming a hopeless junkie, or something of this sort, to the very realistic dangers of the kid getting arrested."

Dr. Alfred Freedman of the New York Medical College comments on one unfortunate aspect of youth's involvement with drugs.

"It's not so much the physical dangers of drugs, which do exist, or that they (the users) will become criminally insane, which is ridiculous, but rather it's the fact that they are developing an inward reality that is most meaningful to them, rather than maintaining a concern with society in general. We are in very difficult times, it seems to me, and the participation of everyone, particularly the younger people, is extremely important. If the focus of their lives becomes centered upon drugs, which often happens, then I think we are losing something."

The booklet also explores the distribution system of drugs including highly profitable heroin and somewhat less lucrative, but nonetheless popular, marijuana. For example, it is pointed out that a kilo of marijuana, which starts out selling for $2, may wind up bringing as much as $500.

Methods for treating hard drug addicts are also explored. The work at various research and therapeutic centers, including the federally-operated hospital in Lexington, Kentucky, and Daytop Village in New York city are discussed.

Concluding chapters present realistic insight into the problem by prominent men in the fields of law enforcement, medicine, and psychology. It is pointed out that society must take the initiative in seeking to change those factors in the environment which are conducive to using drugs as a means for escape.

For copies of the booklet, contact your local Blue Shield office.

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

ROHER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

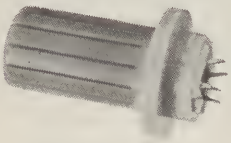
THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

TB is still around.

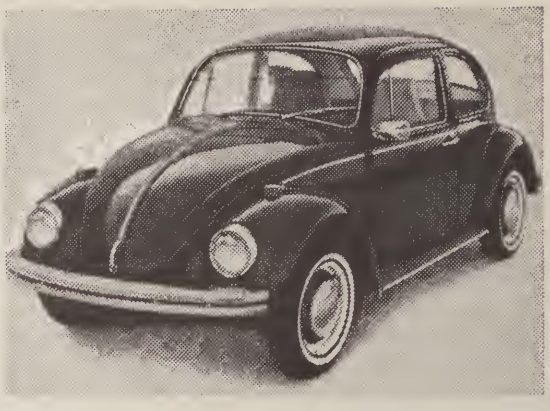
In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.



Live below your means

If you'd like to get around the high cost of living, we have a suggestion.

Cut down on the high cost of getting around. And buy a Volkswagen. It's only **$1799***

* Suggested retail price east coast P.O.E. Local taxes and other dealer delivery charges, if any, additional.

MARYLAND VOLKSWAGEN
1212 E. 25th St.
(corner of Harford Rd.)
BALTIMORE, MD. **Phone 889-7616**

HIGHLAND HOSPITAL

Asheville, North Carolina
Founded 1904
A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY
Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational aotivities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, *Coordinator of Admissions*

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—254-3201



The burdened heart...

The burdened heart, psychic tension, and adjunctive therapy with Valium® (diazepam):



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Roche LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Artist's conception schematically showing varying ischemic ventricular muscle tissue.

To help lift psychic tension from the already burdened heart

When the cardiac patient shows signs of panic-like reactions following initial diagnosis—a daily regimen of 10-mg Valium (diazepam) tablets *t.i.d.* or *q.i.d.* can help control *severe* psychic tension, anxiety, apprehension and agitation. For *less severe* emotional stress, the 5-mg tablet usually provides the desired calming effect.

When the cardiac patient's outlook impedes convalescence—Valium, as it relieves psychic tension, can help the patient regain a realistic perspective... help him deal more rationally with convalescence by countering excessively anxious attitudes towards the future.

When the cardiac patient can't adjust emotionally to post-recovery limitations—Valium, through its prompt and pronounced calming action on psychic tension, may help avoid exacerbation or aggravation of cardiac symptoms.

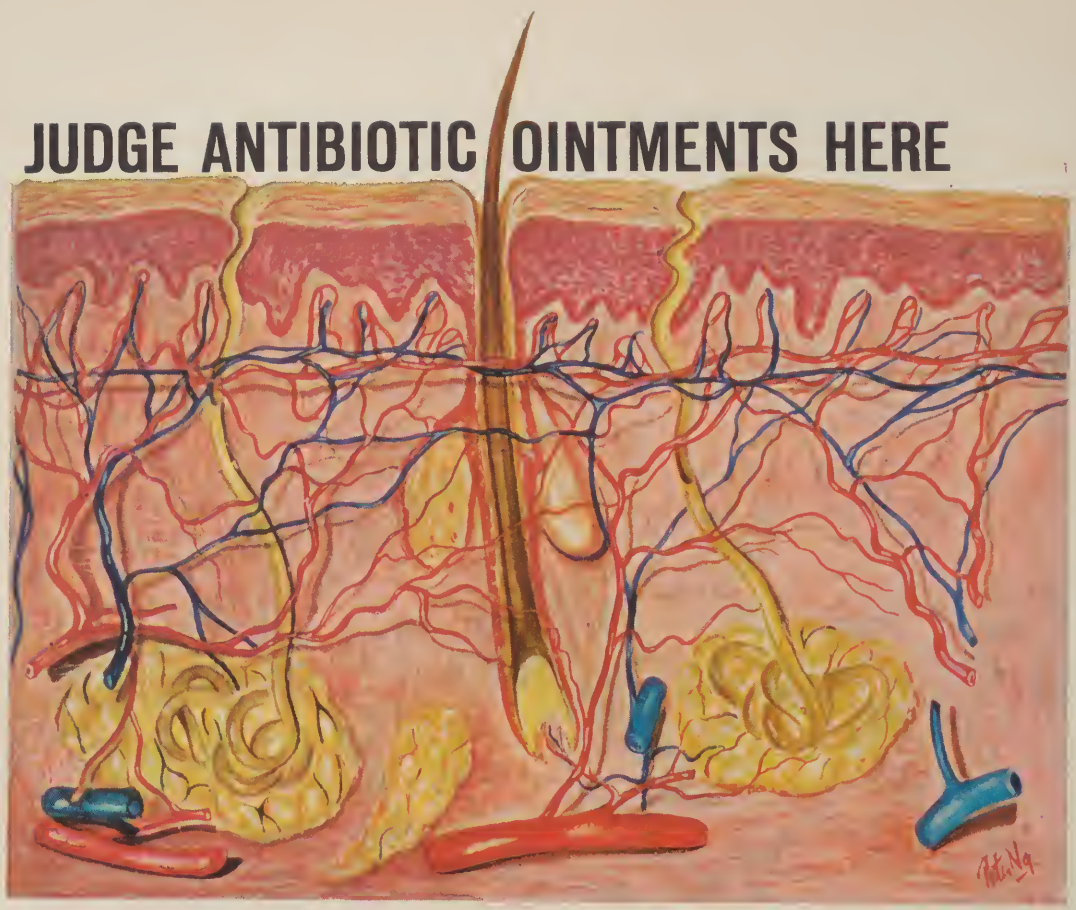
On proper maintenance dosage, Valium seldom dulls the senses or interferes with functioning.

Should anxiety-induced insomnia be a problem— an *h.s.* dose added to the *t.i.d.* schedule usually helps permit a night of restful sleep.

Valium®
(diazepam)

2-mg, 5-mg and 10-mg tablets
t.i.d. and *h.s.*

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

a broad-spectrum antibiotic for the diabetic:

threat or therapy?



Disordered metabolism makes her prone to bacterial infection —and to moniliasis.

When she needs tetracycline, she may also need protection against the threat of fungal overgrowth. And Tetrex-F can provide both.

Each capsule contains 250 mg. of tetracycline phosphate complex to control sensitive bacterial pathogens...and nystatin, 250,000 units, as a precautionary measure against troublesome vaginitis, proctitis or other monilial infections. However, superinfection with other, nonsusceptible organisms may occur.

Tetrex-F®
(tetracycline phosphate complex-nystatin)

PRESCRIBING INFORMATION: Tet-F. 5—2/23/67. For complete information consult Official Package Circular.
Indications: Infections of respiratory, gastrointestinal and genitourinary tracts and skin and soft tissues due to tetracycline-sensitive organisms, in patients with increased susceptibility to monilial infections.
Contraindications: The drug is contraindicated in patients hypersensitive to its components.
Warnings: Photodynamic reactions have been produced by tetracyclines. Natural and artificial sunlight should be avoided during therapy. Stop treatment if skin discomfort occurs. With renal impairment, systemic accumulation and hepatotoxicity may occur. In this situation, lower doses should be used. Tooth staining and enamel hypoplasia may be induced during tooth development (last trimester of pregnancy, neonatal period and childhood).
Precautions: Bacterial superinfections may occur. Infants may develop increased intracranial pressure with bulging fontanels. In gonorrheal therapy, serologic tests for syphilis should be conducted initially and monthly for 3 months.
Adverse Reactions: Glossitis, stomatitis, nausea, diarrhea, flatulence, proctitis, vaginitis, dermatitis, and allergic reactions may occur.
Usual Adult Dosage: 1 capsule q.i.d. Continue for 10 days in Beta-hemolytic streptococcal infections. Administer one hour before or two hours after meals.
Supplied: Capsules, bottles of 16 and 100. Each capsule contains tetracycline phosphate complex equivalent to 250 mg. tetracycline HCl activity and 250,000 units of nystatin.

For Oral Suspension, 125 mg. tetracycline and 125,000 u. nystatin/5 ml., 60 ml. bottles. **A.H.F.S. Category 8:12**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

Pharmacy School Shows Dangers of Drug Abuse

"The pharmacist is in the best position to counsel the general public on the dangers of drug abuse," says David A. Blake, MD, "and the School of Pharmacy should be a resource for educational programs geared to that end."

Dr. Blake, assistant professor of pharmacology, is actively engaged in making such an educational program a reality.

Movies showing the effects of drugs on animals will be incorporated into the lecture presentation Dr. Blake designed for high school showing. Eventually there will be five films dealing with the effects of the five different classes of drugs.

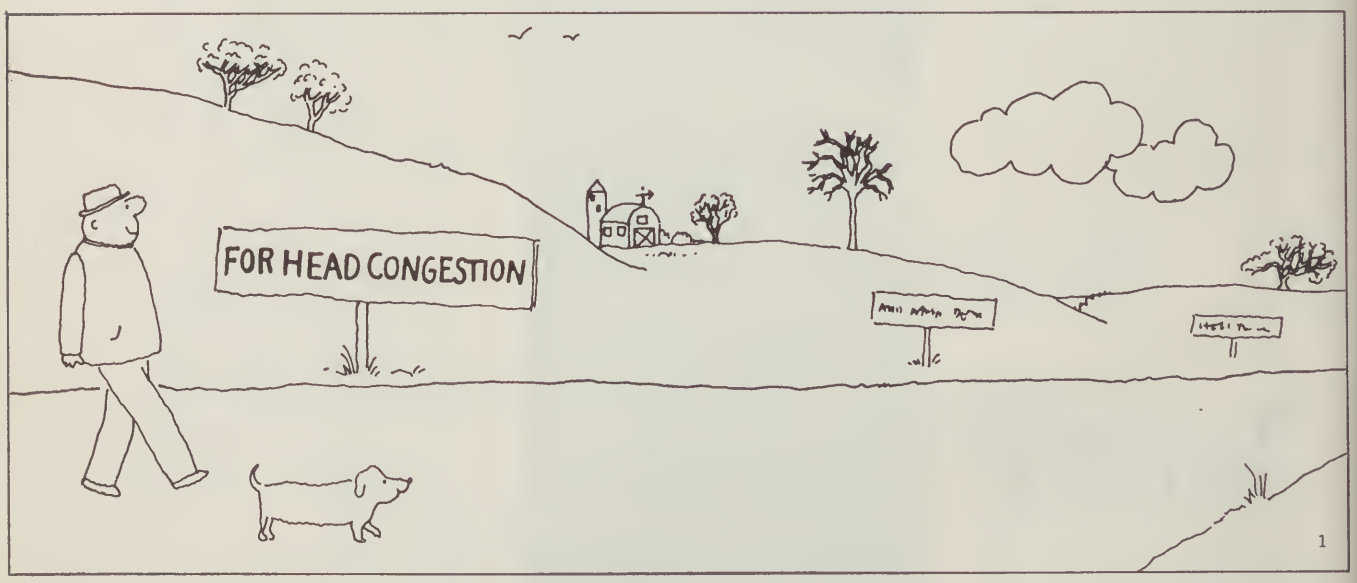
The idea is to provide a graphic representation of the dangers, both emotional and physical, involved in nonmedical drug experimentation.

Since last year Dr. Blake has been presenting drug-abuse programs at area high schools with the aid of Dr. C. T. Ichniowski, professor and head of the department of pharmacology, and pharmacy student volunteers.

The films are the first step in creating a new role for the pharmacy school, that of a drug information center. In addition to the films, the school hopes to be able to provide lecture outlines, slides, and refresher courses for pharmacists, to equip them with the most up-to-date information on the dangers of drug abuse.

"In this way the community pharmacist can expand his role as counselor to the public," Dr. Blake stated.

Advertisement



THE MONTH

IN WASHINGTON

The American Medical Association has offered to cooperate in a Senate investigation of large medicare and medicaid payments to physicians and other health practitioners.

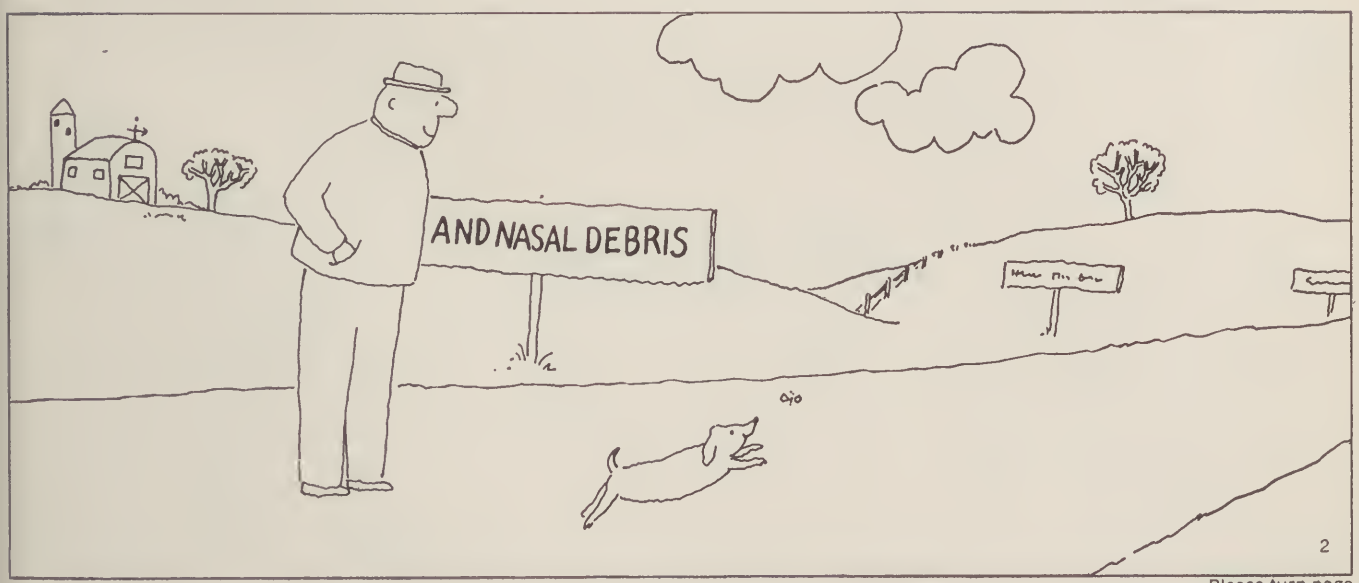
The offer followed a Senate speech by Sen. John J. Williams, (R., Del.), in which he reported that the staff of the Senate Finance Committee had found that several thousand doctors, dentists, and others had received $25,000 or more for their services under the two government programs in 1968.

In a second Senate speech, Williams expressed appreciation for the AMA offer to cooperate.

"This is the type of cooperation we need, and I appreciate this support from the American Medical Association," Williams told the Senate. "I sincerely hope that we shall have similar pledges of support from representatives of the other groups affected.

"I can assure each of these groups that our study will not result in a blanket indictment against any segment of the industry involved. We fully recognize that the overwhelming percentage of those who are in any way connected or working with this program are trying to do a good job; however, when instances of exploitation or excessive charges are discovered they must be exposed and properly dealt with."

Williams, who has announced he will not seek re-election next year, is a member of the Senate Finance Committee which is making an extensive study of the operation of medicaid and medicare.



Please turn page

Williams said that, although a staff report would not be ready until later this summer, the committee's investigation already had shown:

"First, in 1968 the medicare program paid $25,000 or more to each of at least 5,000 physicians.

"Second, thousands of health practitioners—doctors, dentists, optometrists, and others—were each paid $25,000 or more under the welfare health care programs in 1968. . . . A surprising note is the large number of dentists appearing on the lists from welfare agencies. . . .

"Data has also been gathered, and detailed tables prepared, comparing the average medicare payments for the most common surgical procedures for older people with the maximum payments allowed under the most widely held Blue Shield contract in the same geographical area.

"The results are startling. Medicare's average payments run as much as two to four times as high as Blue Shield maximums. For example, in two areas of the country, medicare's average payment for a cataract operation is more than four times as much as the Blue Shield allowance. These are not isolated cases. There is a pronounced pattern of inflated payments by medicare.

"The report to the committee will include pinpointing the causes underlying these extremely generous handouts of public funds.

"Another unusual situation has occurred in Social Security's pressing carriers to pay for so-called supervisory services rendered by a teaching physician, even though the actual care is provided by an intern or resident. Before medicare, virtually no insurer paid for such services. . . .

"The investigation has expanded the evaluation of carrier and intermediary performance to determine whether the Government is getting what it is certainly paying for, and the extent to which intermediaries and carriers are carrying out specific functions assigned to them by the medicare statute.

"Thus far, a wide variance and level of performance has been observed. . . .

"The law requires intermediaries and carriers to exercise effective controls on utilization of services. . . .

"Yet some carriers and intermediaries appear virtually to ignore performance of this vital function while others seem to be doing a reasonably effective job."

Following Williams' first speech, the AMA issued a statement saying that it shared with the Senator a concern over the rising costs of medicare and medicaid. The Association offered to cooperate with the Senate Finance Committee or any other congressional committee studying the problem of rising health care costs. The AMA earlier had made the same offer to Health, Education and Welfare Secretary Robert H. Finch.

The AMA statement said:

"For some time the AMA has been giving national leadership in coordinating the efforts of state and county medical societies in the establishment and effective functioning of local review and utilization committees checking on the health care services rendered under the medicare and medicaid programs. Close liaison also has been established between carriers and



many medical societies in reviewing disbursements under the government programs.

"All investigations so far have indicated that an overwhelming majority of physicians, participating in medicare and medicaid, are charging reasonable fees. The charges of only about 2% of the physicians receiving payments from the programs have been challenged. Of course, the AMA favors appropriate action in any of the cases where physicians are found to receive improper payments. Last June, the AMA Board of Trustees urged all state and local medical societies 'to act swiftly and firmly in all instances of known exploitation, and excessive charges for health care that may occur in their jurisdiction.' In 1967, the AMA said 'any reports of abuses by physicians or by any other health care program should be thoroughly and promptly investigated and action taken where indicated.' Several medical societies have expelled members where it has been proved that a physician's charges were excessive or he in some other way exploited the program.

"The AMA, through its publications and speeches by its officials, has been emphasizing to physicians the responsibility they have to hold down the health care costs of their patients both under and outside government programs. In an April 17 letter to Finch, Dr. Wilbur said the AMA 'is eager to make available to your office the composite experience and judgment of the nation's physicians, who are the principal providers of health care to all the people.'

" 'The knowledge and judgment of the nation's physicians—as well as of the prepayment plans, health insurance industry, hospitals, the allied health professions, the actuaries and others—must be enlisted in your battle against the health-care portion of the inflation problem,' Dr. Wilbur said."

* * *

The House passed and sent to the Senate a three-year $937 million extension of the Hill-Burton Act under which the federal government has helped finance construction of hospitals and nursing homes with 425,000 beds.

Members approved the measure on a 351 to 0 roll call after turning down a series of amendments designed to channel more of the matching hospital grants to big cities than urban areas, and into modernization rather than new hospital construction.

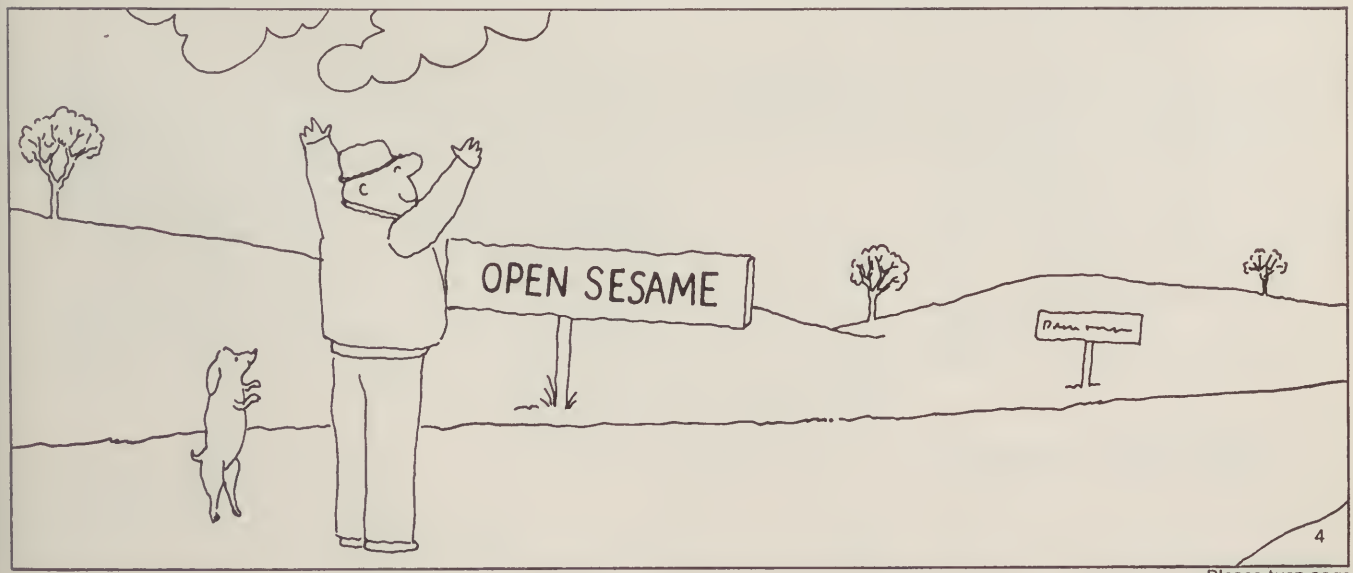
In addition to extending existing aid, the bill provides new loan guarantees, as requested by the Nixon Administration, and interest subsidies, which the Administration opposed.

The bill, as passed, authorizes appropriations (over three years) up to $405 million for hospital construction; $165 million for modernization; and $300 million in guaranteed loans, toward which the government would contribute up to $37 million in 3% interest subsidies. In addition, grants up to $30 million could be made for emergency room modernization.

* * *

The American Medical Association urged that Congress approve full appropriations for medical education programs.

C. H. William Ruhe, MD, director of the AMA's Division of Medical Education, testified be-



Please turn page

fore a House appropriations subcommittee that the nation's urgent need for more physicians could "only be met effectively by a major increase in the capacity of American medical schools to educate more physicians.

"It is, therefore, appropriate to emphasize again that full funding, in the amounts authorized by the Health Manpower Act of 1968, is necessary to permit the construction of new and expanded facilities before major enrollment increases will be feasible," Dr. Ruhe said.

In a letter to the House Public Health and Welfare Subcommittee, the AMA also supported extension of the Medical Library Assistance Act. **Ernest B. Howard, MD,** AMA executive vice-president, said that "we cannot exaggerate the importance to the health professions and the public they serve" of the many beneficial services supported through the programs.

* * *

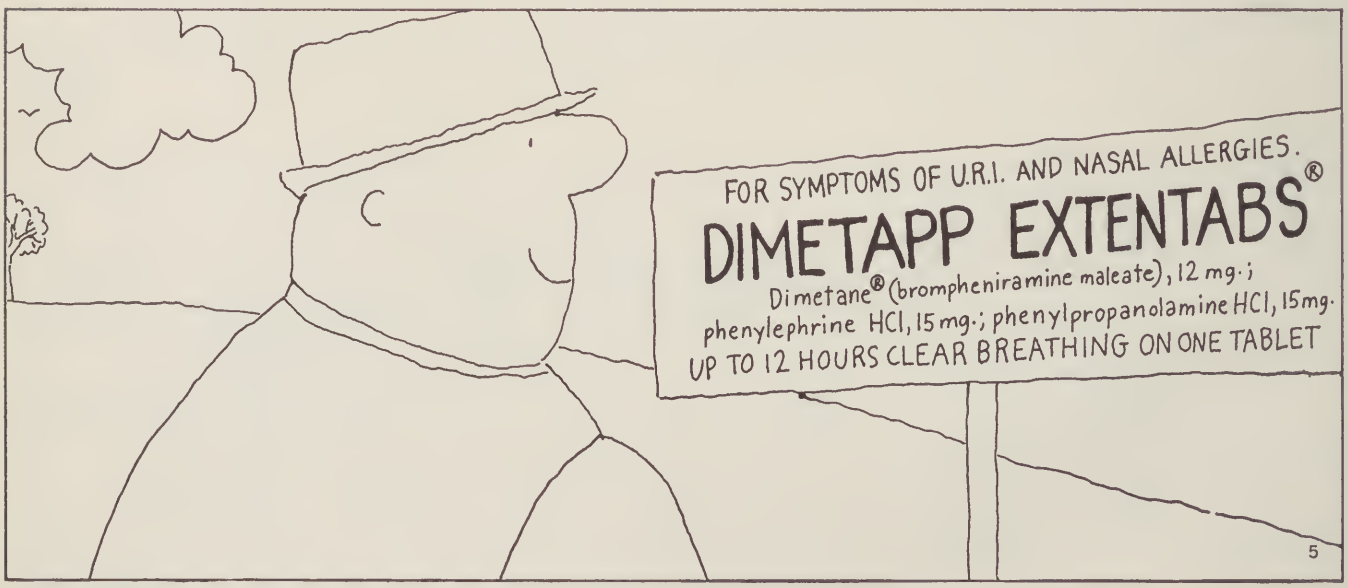
President Nixon created the cabinet-level Environmental Quality Council to begin a major attack on pollution of the environment. He also named a companion 15-member Citizens' Advisory Committee on the recommendations of Lee A. Dubridge, PhD, his chief science adviser.

The President said the council, serving as an advisory board on a par with the National Security Council and the Urban Affairs Council, "will provide the focal point for this Administration's efforts to protect all of our natural resources."

Dubridge stated that "the problem is how we can make maximum use of our environment . . . without despoiling it." He said the council would move promptly on the problems of disposal of waste products—a key factor in deterioration of the environment.

The President will head the council, which also will include the Vice-President, and the Secretaries of Agriculture, Commerce, Health, Education and Welfare, Housing and Urban Development, Interior and Transportation.

Laurence S. Rockfeller, one of the nation's leading conservationists and a key figure in Lady Bird Johnson's National Beautification Campaign, will be chairman of the Citizens' Advisory Committee.



Pamphlet on Leukemias, Lymphomas, and Myelomas Offered

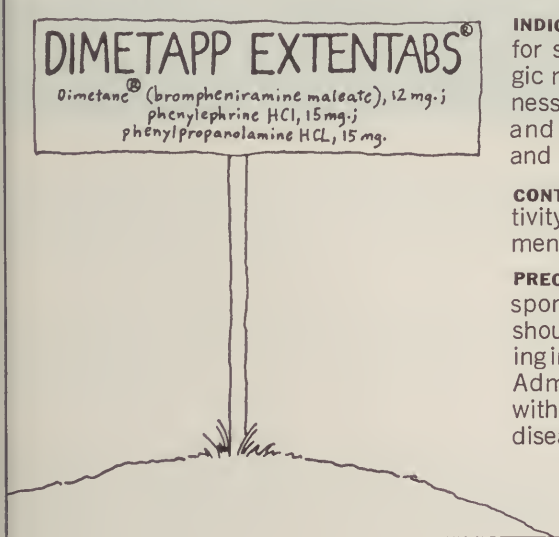
Leukemias, lymphomas, and multiple myelomas are cancers of the blood-forming and lymphoid organs. Because these cancers involve abnormal growth of cells with similar functions and origins, they are considered related.

Symptoms, treatment, and research on these diseases are discussed in a pamphlet, "Leukemias, Lymphomas, and Multiple Myeloma," issued recently by the U. S. Department of Health, Education, and Welfare. It is the latest in a series of pamphlets on cancer prepared for the general public by the National Cancer Institute, NIH.

Encouraging progress has been made in extending the survival of acute leukemia patients, according to the pamphlet. This improvement is due to chemotherapy (treatment with drugs), and the development of better methods of patient care. At present, a number of anticancer drugs can bring about complete remissions (absence of any symptoms of the disease) in patients with acute leukemia; the drugs are particularly useful in childhood leukemia.

Lymphoma and multiple myeloma are responsive to both radiotherapy and drug treatment. To achieve better control of these diseases, physicians and scientists throughout the country have been cooperating in a number of research and planning efforts sponsored by the National Cancer Institute.

Single copies of "Leukemia, Lymphoma, and Multiple Myeloma" (PHS Publication No. 1768) are available without charge from the Department of Health, Education, and Welfare, Washington, D. C. 20402. The pamphlet may be purchased from the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402 at 10¢ a copy or $5 per 100 copies.



INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, hayfever and conjunctivitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

DOSAGE: 1 Extentab morning and evening.

SUPPLIED: Bottles of 100 and 500.

A-H-ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

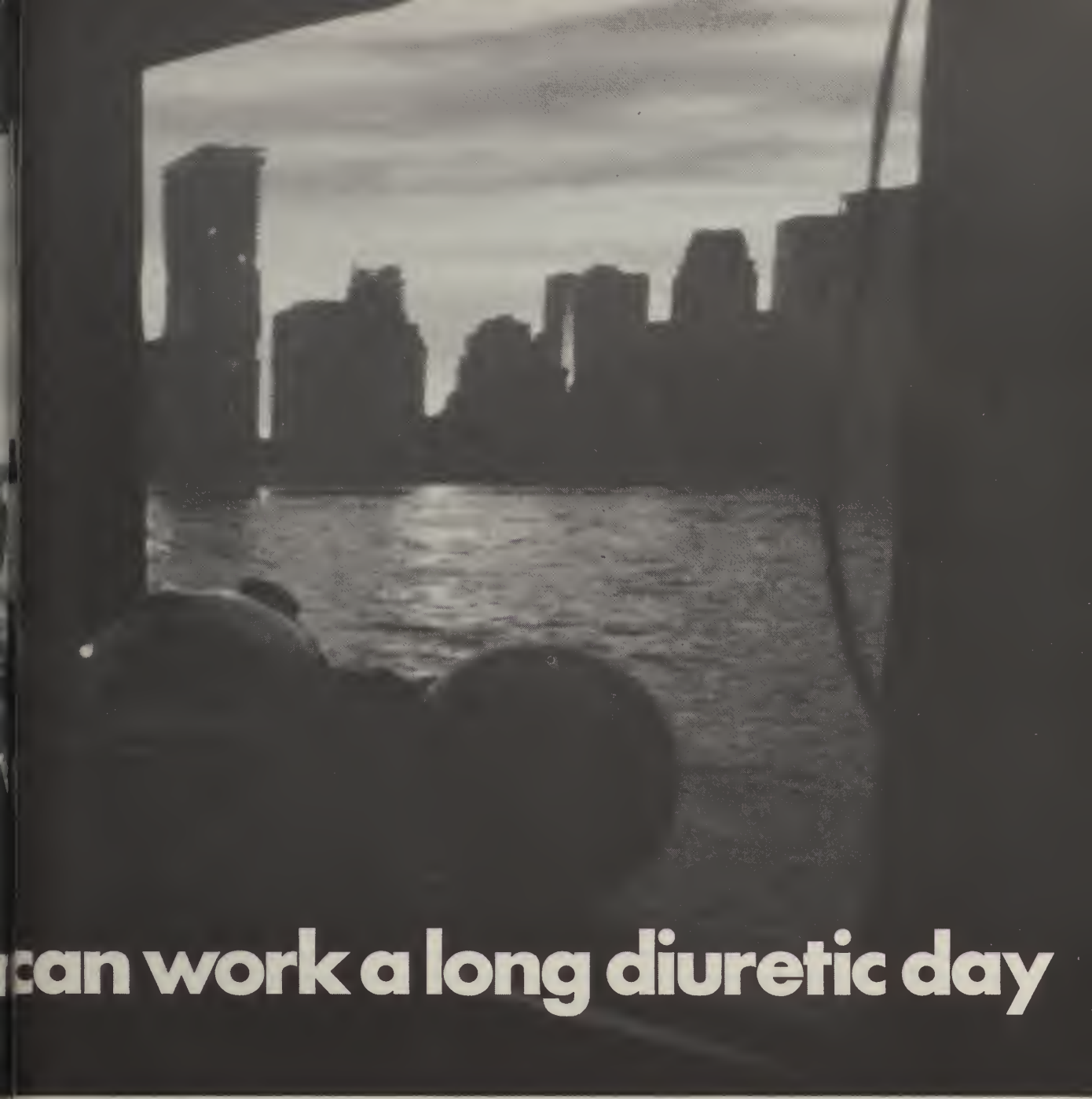
6



A little Hygroton

chlorthalidone

HY-6674



can work a long diuretic day

ll the way from one daily tablet to the next
o help control edema and hypertension

s prolonged action usually provides smooth, sustained diuretic ffectiveness; real one-a-day dosage, right from the start; convenience nd economy.

Hygroton, chlorthalidone, can cause side effects. And it's contra-ndicated in hypersensitivity to the drug and severe renal and epatic diseases.

Check the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-6674

ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

MEETING NOTES

The Board of Directors of the Baltimore City Medical Society met on May 13, 1969 at 4:30 PM. The meeting was called to order by the President, Raymond C. V. Robinson, MD.

The minutes of the April 1, 1969 meeting were approved.

The first item on the agenda was a financial report by the Treasurer, Emmanuel A. Schimunek, MD. Dr. Schimunek has reviewed and discussed the financial status of the Society with persons knowledgeable in the field of finance, and he presented two proposals to the Board. These were, first, that the treasurer be bonded, and secondly, that the finances of the Society be placed with the trust department of a bank or with an investment firm. It was agreed that a bond for the treasurer should be purchased and that Dr. Schimunek should investigate further the idea of placing the Society's funds with an investment company. This would assure periodic review and updating of the Society's investments, providing a better return on the funds invested.

The subject of collection of fees for laboratory services by physicians had been discussed previously, and it had been proposed that a letter be sent to the Section on Internal Medicine asking its opinion. However, Edward F. Cotter, MD, reported that he had spoken with Gordon Cader, MD, president of the Section on Internal Medicine, and the Section had decided that as long as the physician was allowed to charge a fee for taking laboratory specimens, no further action would be initiated.

The next item on the agenda was a report submitted by Edward F. Cotter, MD, Chairman of the Committee to Study Hospital Privileges. Dr. Cotter submitted for approval a questionnaire designed by his Committee. This questionnaire will be mailed to all city physicians in the fall.

In addition, it was suggested that this type of questionnaire might well be utilized by the Board of Medical Examiners for the computation of similar information on a state-wide basis. This subject will be discussed with the Secretary of the Board.

A copy of the questionnaire with a brief prelude is as follows:

Since there is a shortage of physicians and hospital beds, it is reasonable to question whether both are being utilized most effectively and efficiently for the benefit of the community. The answer to this question can best be obtained by a survey of physicians in Baltimore. This information is necessary before appointing a larger committee to study in more detail and make recommendations to the Board of the Baltimore City Medical Society.

The Committee believes that there can and should be a meaningful exchange of information and services in the area of primary care existing between hospitals and all practicing physicians in the community, especially those physicians in the immediate neighborhood or area of the hospital. Would you express any ideas you may have on this?

The following questionnaire is proposed:

NAME: .....

Office address: .....

Postgraduate education:

Internship .....

(Continued next page)

First-year residency .....

Second-year residency .....

Third-year residency .....

Fourth-year residency .....

Board Certified or Board Eligible .....

Fellowship .....

Additional .....

Type of practice .....

Hospital	*Type of privileges*	*Department*
	Active	Medicine .....
	Associate	Surgery .....
	Other	Gyn-Ob .....
		Pediatrics .....
		Other .....

Additional hospitals in which privileges are desired and give reasons for the need:

If you do not have hospital privileges, please state reasons why they have not been obtained:

With regard to hospital(s) in which you have privileges, state whether your interests and contributions include:

(a) Continuing medical education Yes....., No.....

If yes, complete the following as to your interests:

(1) Attendance at departmental conferences Yes....., No.....

(2) Participation in departmental conferences Yes....., No.....

(3) Teaching responsibilities Yes....., No.....

(4) Work in outpatient department Yes....., No.....

(b) Committee assignments Yes....., No.....

(c) Courtesy privileges Yes....., No.....

With regard to hospital(s) in which you desire privileges, state whether your interests and contributions would include:

(a) Continuing medical education Yes....., No.....

If yes, complete the following as to your interests:

(1) Attendance at departmental conferences Yes....., No.....

(2) Participation in departmental conferences Yes....., No.....

(3) Teaching responsibilities Yes....., No.....

(4) Work in outpatient department Yes....., No.....

(b) Committee assignments Yes....., No.....

(c) Courtesy privileges Yes....., No.....

The action of the House of Delegates regarding the Report of the Bylaws Committee was then discussed. The report, as originally presented, would have amended the Bylaws of Med-Chi to state that all councilors would be elected on a district basis, without guaranteeing any specific number of councilors to any component society. The Amendment, presented by the Baltimore City Medical Society delegation, proposed that a specific number of councilors should be guaranteed to certain components. After heated debate in the House of Delegates, both the original report and the suggested amendment were referred back to the Bylaws Committee for further study and report at the next meeting of the House.

A list of proposed general meeting dates of the Society for the remainder of 1969 and 1970 were presented and approved by the Board. The dates approved are as follows:

GENERAL MEETINGS 1969 and 1970
Thursday, October 2, 1969, 8:30 PM.
Thursday, November 6, 1969, 8:30 PM.
Thursday, December 4, 1969, 8:30 PM.
Friday, January 2, 1970, 8:30 PM.
(first Thursday is New Year's Day)
Thursday, February 5, 1970, 8:30 PM.
Thursday, March 5, 1970, 8:30 PM.
Thursday, April 9, 1970, 8:30 PM.
(Med-Chi Annual Meeting April 1, 2, 3)
Thursday, October 1, 1970, 8:30 PM.
Thursday, November 5, 1970, 8:30 PM.
Thursday, December 3, 1970, 8:30 PM.

Two of these dates require some explanation. The first Thursday in January is New Year's Day and the first Thursday in April falls on the same date of the Med-Chi Annual Meeting. Therefore, these two meeting dates had to be changed.

The Board agreed to suspend the July and August meetings of the Board of Directors in accordance with past practice. In the event that urgent, pressing matters should arise, a meeting of the Board will be called.

The next item considered by the Board was a discussion of the addition of an extra telephone line to the Baltimore City Medical Society business office. The reason for the suggestion was that the telephone load, incoming and outgoing from the office, has increased tremendously during recent years. The Board unanimously agreed that an extra private line should be installed.

Philip F. Wagley, MD, then presented the proposed Health Sciences Consortium for the approval of the Board. This committee was to help establish scientific courses within the existing community colleges which might be interrelated. The ultimate purpose of this consortium is to broaden the over-all availability for the training of paramedical personnel within the existing facilities. Sanction by the City Medical Society was requested in order to strengthen the application for approval of such a program by federal agencies and to obtain support from the National Institutes of Health. After brief discussion, the Board agreed to lend its support to such a program, however, it was noted that many problems in the organization and delivery of such a concept were obviously forthcoming.

The Board of Directors was asked for help in obtaining payment of delinquent loans offered through the "Student Loan Fund" operated by the Woman's Auxiliary. The Board agreed to write the delinquent physicians a letter urging them to repay the fund in the manner originally agreed upon. If results are not achieved through such a reminder, the Board recommended that national and local medical societies, to which these physicians belong, be informed of this delinquent obligation.

The subject of the disposition of an unfortunate physician with the problem of narcotic addiction was discussed by the Board, but since the physician has voluntarily surrendered his narcotics license and entered a psychiatric institution for therapy, no action was necessary.

The Board was then beset with an arduous task presented by the Baltimore City Health Department to investigate one of the Society's members with regard to an allegedly unsanitary atmosphere in which he practices medicine. The Board decided to write a letter urging "the physician in question" to comply with the standards set by the Baltimore City Health Department.

John B. De Hoff, MD, Director of Local Health Services for the Baltimore City Health Department, requested the Board to recommend means of providing pre-camp and pre-employment physical examinations. Several of the members of the Board were of the opinion that in the past this experience has been extremely unpleasant, and it was agreed to suggest to Dr. De Hoff that these patients, who for the most part are under the age of 18, be referred to the "600 Series Project" within their individual location.

The meeting was adjourned at 6:15 PM.

Al-Lin Ambulance Service
"AT THE BELTWAY"
4811 E. LEEDS AVE. BALTIMORE, MD. 21227
24 Hour Emergency Ambulance and Oxygen Service
Trained and Experienced Personnel
2 Way Radio Controlled
247-2111

For elderly patients
in need of a mild tranquilizer
consider **Tybatran®**
brand of tybamate

(When you consult
the Prescribing Information
you may agree
it makes good sense)



PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

DRINK MORE MILK
for your health sake



- More Vitamins
- More Minerals
- More Energy



Deliveries in Maryland, Washington, and Virginia.

Looks Delicious, Tastes Beautiful.

EMBASSY DAIRY
DU 7-1441
1620 First St. N.W.
Washington, D.C.

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545

DOCTORS' OFFICES

LARGE

MEDIUM

SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST.

CORPORATION

11 E. Chase St.

Phone 539-8553

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION

ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE
DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily
Tuesday Evenings 7 to 9

355-9300

PATAPSCO AVENUE & FOURTH STREET

Baltimore, Maryland, 21225

Dulcolax®...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



UNDER LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU-6681



Clues to PVD The geriatric smoker

In studies on peripheral vascular disease—a common by-product of the degenerative aging process—considerable attention has focused on the important role of smoking in the progression of the disease. Although it may not be etiologic, smoking is widely recognized as a prominent contributing factor.[1]

Skin blood flow—significant factor in PVD. Cutaneous digital vasoconstriction caused by nicotine has been observed both in normal subjects and in patients with peripheral vascular disorders.[1,2] Among patients with peripheral vascular disease, however, age and the severity of the disease appear to modify the effects of nicotine. For example, in a study of older patients with *marked* peripheral vascular disease,[3] changes induced by smoking were not statistically significant for the group as a whole. This was explained on the basis of decreased skin reactivity. *Smoking is not permissible in any stage of the disease,* since even "... minimal reduction in blood flow in patients with ischemic limbs may produce a further reduction in tissue nutrition, and thus may be another case of the proverbial straw on the camel's back."[3]

In another study of patients with peripheral vascular disease,[4] the investigators stress that decreased skin blood flow during smoking "... is the factor of most importance to the patient with peripheral vascular disease." *While such patients may adjust to the discomfort of vascular insufficiency in skeletal muscle, decreased skin blood flow may often lead to severe symptomatology.*

More and more physicians have adopted the practice of investigating for peripheral vascular disorder when confronted with a geriatric patient who is a habitual smoker. Once a diagnosis is established, therapeutic measures are directed toward increasing the peripheral circulation and appropriate management of the patient's general medical needs. These include the important safeguards of keeping warm and refraining from smoking.

Professional model posed for illustration.

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.
Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.
Selectivity of action—relaxes the musculature of peripheral blood vessels.
High degree of safety—side effects seldom require discontinuation of therapy.

Before prescribing, please consult complete product information, a summary of which follows:
Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.
Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.
Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.
Dosage: 1 or 2 Timespan Tablets morning and night.
How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt, bottles of 50.

References: (1) Roth, G. M.; Shick, R. M., and Secrest, R. R., in James, G., and Rosenthal, T., eds.: *Tobacco and Health*, Springfield, Ill., Charles C Thomas, 1962, pp. 311-322. (2) Entmacher, P. S.: Proc. Med. Sect. Amer. Life Convention *51*:149, 1963. (3) Freund, J., and Ward, C.: Ann. New York Acad. Sci. 90:85, 1960. (4) Coffman, J. D., and Javett, S. L.: Circulation 28:932, 1963.



Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



"All Registered Nurses are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards. Therefore, all registered nurses are alike.

That's nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all registered nurses aren't alike, either.



- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE
EVANGELICAL
PRESS

THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

*"Making Good Impressions
Through Good Impressions"*

*"The Best of Care
for Those You Love"*



Pleasant Manor
CONVALESCENT AND NURSING CENTER

*ONE OF THE NEWEST, MOST MODERN
PARA-MEDICAL FACILITIES*

Round-the-clock care by Professional Staff
Complete Intensive Care Units
Physical and Occupational Therapy

Excellent Meals--Kosher Food on Request
Air-Conditioned, Fire-resistant Building
Centrally Located Near Sinai Hospital
Your Inspection Invited

4615 PARK HEIGHTS AVE.
BALTIMORE, MD.
542-4800

Achromycin V
250 mg. capsules

ACHROMYCIN® V
TETRACYCLINE HCl
Lederle
481D-9

**T. ROWE PRICE
GROWTH STOCK
FUND, INC.**

BALTIMORE, MARYLAND

A stock portfolio carefully selected
for possible growth of principal and income.

NO SALES CHARGE
NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And free your secretary to be your secretary again.

professional systems and services *division of*

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3886



ANNUAL FINANCIAL STATEMENT
of the
Medical and Chirurgical Faculty
of the State of Maryland

April 23, 1969

CERTIFICATE

The Medical and Chirurgical Faculty
of the State of Maryland,
1211 Cathedral Street,
Baltimore, Maryland 21201

Gentlemen:

We have made an audit of the records of the Treasurer of The Medical and Chirurgical Faculty of the State of Maryland for the year ended December 31, 1968. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures that we considered necessary in the circumstances.

In our opinion, the balance sheet, together with the supporting statements, present fairly the financial position of the Faculty as of December 31, 1968 and the results from operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

WOODEN, BENSON & WALTON

THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND
Baltimore, Maryland

BALANCE SHEET—DECEMBER 31, 1968

EXHIBIT A

ASSETS

General Fund			
Cash			
Maryland National Bank			
Regular checking		90,878.48	
Payroll		11,170.08	
Savings account		235,868.50	
Petty cash fund		400.00	338,317.06
Accounts Receivable			
Membership Dues, journal subscriptions, etc.		17,363.62	
Due from Other Funds			
Med-Chi Insurance Trust Fund	2,304.15		
Consolidated Fund	1,496.09		
Steiner Fund	362.04	4,162.28	21,525.90
Loan Receivable			
Plant Fund			30,000.00
Deferred Charges			
Air travel		425.00	
Annual meeting		250.00	
Insurance premiums		1,569.28	2,244.28
Total General Fund Assets			392,087.24
Endowment and Other Special Funds			
Consolidated fund—Exhibit A-1			266,774.98
Funded Reserve—Exhibit A-2			17,053.30
Harvey G. Beck—Lectureship fund—Exhibit A-3			3,292.84
Jesse C. Coggins			
Lectureship			
Cash—Maryland National Bank		5,267.36	
New Building Fund—Exhibit A-4		193,036.79	198,304.15
George M. Boyer—Lectureship Fund			
Cash—Loyola Federal Savings and Loan Association			5,353.03
Amos Koontz—Memorial Fund—Exhibit A-5			2,787.94
Educational Fund—Exhibit A-6			58,633.33
Medical Annals Fund			
Cash—National City Bank			1,331.39
Henry P. Laughlin—Special Award Fund			
Cash—Loyola Federal Savings and Loan Association			2,715.31

LIABILITIES AND CAPITAL

General Fund		
Liabilities		
Accounts Payable		
Trade	9,918.48	
American Medical Association—dues collected	73,165.00	
Component Medical Societies	51,271.00	
Education Fund	20.34	
Plant Fund	7,990.00	142,364.82
Payroll Taxes		
Withholding		
Federal	575.45	
State	2,026.39	
Old Age Benefit	856.27	
Unemployment insurance		
Federal	391.57	
State	21.24	3,870.92
Designated Fund—Library Account—books and journals		2,898.61
Deferred income—1969 dues		103,295.00
Surplus—Exhibit C		139,657.89
Total General Fund—Liabilities and Capital		392,087.24
Endowment and Other Special Funds		
Consolidated Fund—Exhibit A-1		266,774.98
Funded Reserve—Exhibit A-2		17,053.30
Harvey G. Beck—Lectureship Fund—Exhibit A-3		3,292.84
Jesse C. Coggins		
Lectureship—capital—Exhibit J	5,267.36	
New Building Fund—Exhibit A-4	193,036.79	198,304.15
George M. Boyer—Lectureship Fund—Capital		5,353.03
Amos Koontz—Memorial Fund—Exhibit A-5		2,787.94
Educational Fund—Exhibit A-6		58,633.33
Medical Annals Fund—Capital—Exhibit M		1,331.39
Henry P. Laughlin—Special Award Fund—Capital		2,715.31

J. Mason Hundley Memorial Fund				J. Mason Hundley Memorial Fund—Capital		6,387.76
Cash—Loyola Federal Savings and Loan Association			6,387.76			
Lewis H. Steiner Fund—Exhibit A-7			386,984.34	Lewis H. Steiner Fund—Exhibit A-7		386,984.34
Immunization Fund				Immunization Fund—Capital		5,633.36
Cash—Loyola Federal Savings and Loan Association			5,633.36			
Total—Endowment and Other Special Funds			955,251.73			955,251.73
Plant Fund				*Plant Fund*		
Cash—Maryland National Bank			144.69	Liabilities		
Accounts Receivable—general fund			7,990.00	Jesse C. Coggins—New Building Fund		
Fixed Assets—(No depreciation provided)				—Principal account	44,283.02	
1215-1217 Cathedral Street—land—cost		19,118.95		—Income account	750.00	
1209-1215 Cathedral Street				Loan payable—General Fund	30,000.00	75,033.02
Land—building—cost	110,635.76			Capital—Exhibit O		768,101.33
Improvements—cost	331,525.47	442,161.23				
*Personal Property						
Library books, journals	231,370.00					
Office, library, fixtures, antiques and museum pieces	77,349.48					
Portraits	65,000.00	373,719.48	834,999.66			
Total—Plant Fund Assets			843,134.35	Total Plant Fund Liabilities and Capital		843,134.35
Med-Chi Insurance Trust Fund				*Med-Chi Insurance Trust Fund*		
Cash—Maryland National Bank—checking			10,988.59	Liabilities		
Accounts Receivable				Subscriber overpayments		295.30
Subscriber fees needed to pay consulting and legal fees—Contra			4,980.00	Edward H. Friend and Company—Consulting actuaries		1,707.59
Prepaid Insurance premiums			117.92	Mercantile Safe Deposit and Trust Company—legal and consulting fees—contra		4,980.00
				Due general fund for expenditures		2,304.15
				Others		786.00
						10,073.04
				Capital—Exhibit P		6,013.47
Total Med-Chi Insurance Trust Fund assets			16,086.51	Total—Med-Chi Insurance Trust Fund Liabilities and Capital		16,086.51
Grand Total—All Funds			2,206,559.83	Grand Total—All Funds		2,206,559.83

* The appraised value of portraits as of December 31, 1963 was $65,000.00, an increase of $51,000.00 over prior years. All other personal property appraised as of December 31, 1949, with subsequent additions at cost.

STATEMENT OF INCOME, EXPENSES AND TRANSFERS

For Year Ended December 31, 1968

GENERAL FUND

EXHIBIT B

Income			
Dues—Baltimore City Dental Society	1,865.00		
—Baltimore City Medical Society	106,245.00		
—Component Societies	120,120.00	228,230.00	
Rents and Services			
Baltimore City Medical Society	25,943.00		
Others	6,945.00	32,888.00	
Meetings—annual and semiannual exhibits		21,250.50	
Journal—Advertising	81,659.81		
—Subscriptions	1,245.84	82,905.65	
Addressograph service		754.84	
Interest on savings accounts		8,784.85	
Miscellaneous		3,574.65	
		378,388.49	
Transfers from Consolidated Fund—income for general purposes—Exhibit F		4,807.34	
Total Income and Transfers			383,195.83
Expenses			
Accounting fees		1,800.30	
Communications—postage, telephone and telegraph		11,344.74	
Contributions		350.00	
Equipment rental and maintenance		4,476.36	
Fuel		1,491.79	
Gas, electricity and water		5,490.60	
Household and janitorial services		2,099.51	
Insurance—general		2,169.60	
—hospitalization		3,371.26	
Journal expenses—printing and commissions		90,672.04	
Legal fees		6,465.00	
Legislature		5,780.36	
Property maintenance		5,072.54	
Meetings—annual and semiannual		27,799.64	
Office supplies		3,418.60	
Purchases of equipment		3,513.71	
Pension and Major Medical contribution		13,532.26	
Printing		5,205.22	
Salaries		158,880.24	
Social Security tax—employer's portion		6,487.10	
Unemployment Insurance—Federal		391.57	
—State		264.35	
Travel		8,212.55	
Supplementary hours		2,269.63	
Library		3,088.33	
Interest—Coggins Fund		5,500.00	
Presidential Fund		164.50	
Miscellaneous		2,878.98	
Woman's Auxiliary		1,000.00	
Total Expenses			383,190.78
Excess of Income and Transfers Over Expenses—To Exhibit C			5.05

STATEMENT OF SURPLUS

For Year Ended December 31, 1968

GENERAL FUND

EXHIBIT C

January 1, 1968—Balance	139,652.84
Addition	
Excess of Income and Transfers over expenses for year ended December 31, 1968—Exhibit B	5.05
December 31, 1968—Balance to Exhibit A	139,657.89

BALANCE SHEET—DECEMBER 31, 1968

CONSOLIDATED FUND

EXHIBIT A-1

ASSETS

Income Account			
Cash—The Savings Bank of Baltimore—Exhibit F			
Eugene Cordell Fund	12,965.15		
Special account	19,018.65	31,983.80	
Dividends receivable—Exhibit F		2,190.41	
Investments			
Eugene Cordell Fund—held by Maryland National Bank—Agent—Exhibit F			
Cash	299.09		
Common stocks	8,598.54	8,897.63	43,071.84
Principal Account			
Held by Maryland National Bank—Agent			
Cash		915.94	
Investments—at cost			
Bonds			
United States Government and Municipals	10,618.12		
Others	93,481.65	104,099.77	
Stocks		118,687.43	223,703.14
Total—Income and Principal Accounts Assets—to Exhibit A			266,774.98

LIABILITIES AND CAPITAL

Income Account			
Liabilities			
Due—General Fund	1,496.09		
—Lewis H. Steiner Fund	1,080.77		
Total—Exhibit F		2,576.86	
Capital—Exhibit E		40,494.98	43,071.84
Principal Account			
Capital—Exhibit G			223,703.14
Total—Income and Principal Accounts Liabilities and Capital—To Exhibit A			266,774.98

BALANCE SHEET—DECEMBER 31, 1968 — EXHIBIT A-2
FUNDED RESERVE

ASSETS

Income Account			
Cash—Savings Bank of Baltimore		3,107.33	
Due from principal account—contra		480.34	3,587.67
Principal Account			
Investments—held by Maryland National Bank—Agent			
Cash		233.32	
United States Government Bonds	2,284.38		
Common stock	10,947.93	13,232.31	13,465.63
Total—Income and Principal Accounts Assets—To Exhibit A			17,053.30

LIABILITIES AND CAPITAL

Income Account			
Capital—Exhibit H			3,587.67
Principal Account			
Liability			
Due—income account—contra		480.34	
Capital—Exhibit H		12,985.29	13,465.63
Total—Income and Principal Accounts—Liability and Capital—To Exhibit A			17,053.30

BALANCE SHEET—DECEMBER 31, 1968 — EXHIBIT A-3
HARVEY G. BECK—LECTURESHIP FUND

ASSETS

Income Account			
Cash—Savings Bank of Baltimore			1,213.74
Principal Account			
Investments—held by Maryland National Bank—Agent			
Cash		109.36	
Common stock		1,969.74	2,079.10
Total—Income and Principal Accounts Assets—To Exhibit A			3,292.84

LIABILITIES AND CAPITAL

Income Account			
Liabilities			None
Capital—Exhibit I			1,213.74
			1,213.74
Principal Account			
Capital—Exhibit I			2,079.10
Total—Income and Principal Account Liabilities and Capital—To Exhibit A			3,292.84

BALANCE SHEET—DECEMBER 31, 1968
JESSE C. COGGINS—NEW BUILDING FUND

EXHIBIT A-4

ASSETS

Income Accounts			
Cash—Loyola Federal Savings and Loan Association	26,286.79		
—Maryland National Bank	46.80	26,333.59	
Accrued Interest on Loan to Plant Fund		750.00	
Investment—at cost		63,953.20	91,036.79
Principal Account			
Accounts Receivable			
Due from Plant Fund		44,283.02	
Due from income account—contra		57,716.98	102,000.00
Total—Income and Principal Accounts Assets—To Exhibit A			193,036.79

LIABILITIES AND CAPITAL

Income Account		
Liabilities		
Due to principal account—contra	57,716.98	
Capital (includes $7,280.17 of interest earned during year)	33,319.81	91,036.79
Principal Account		
Capital		102,000.00
Total—Income and Principal Account Liabilities and Capital—To Exhibit A		193,036.79

BALANCE SHEET—DECEMBER 31, 1968
AMOS KOONTZ—MEMORIAL FUND

EXHIBIT A-5

ASSETS

Principal Account	
Cash—Loyola Federal Savings and Loan Association	2,787.94
Total Principal Account Assets—To Exhibit A	2,787.94

LIABILITIES AND CAPITAL

Principal Account	
Liabilities	None
Capital—Exhibit K	2,787.94
Total—Principal Account Liabilities and Capital—To Exhibit A	2,787.94

BALANCE SHEET—DECEMBER 31, 1968
EDUCATIONAL FUND

EXHIBIT A-6

ASSETS

Principal Account	
Cash—Maryland National Bank—savings account	58,612.99
Account receivable—due from General Fund	20.34
Total—Principal Account Assets—To Exhibit A	58,633.33

LIABILITIES AND CAPITAL

Principal Account	
Liabilities	
Due to General Fund for expenditures	None
Capital—Exhibit L	58,633.33
Total—Principal Liabilities and Capital—To Exhibit A	58,633.33

BALANCE SHEET—DECEMBER 31, 1968
LEWIS H. STEINER FUND

EXHIBIT A-7

Income Account — ASSETS		
Cash—Savings Bank of Baltimore	18,171.70	
Dividend receivable	852.20	
Total Income Account Assets		19,023.90
Principal Account		
Uninvested cash—Maryland National Bank	3,102.57	
Due from income account—contra	4,079.64	
Due from Consolidated Fund	1,080.77	
Investments—at book value	359,697.46	
Total Principal Account Assets		367,960.44
Grand Total—Income and Principal Account Assets—To Exhibit A		386,984.34
Income Accounts — LIABILITIES AND CAPITAL		
Liabilities		
Due to General Fund for expenditures	362.04	
Due to principal account—contra	4,079.64	4,441.68
Capital—Exhibit N		14,582.22
Total Income Account Liabilities and Capital		19,023.90
Principal Account		
Capital—Exhibit N		367,960.44
Grand Total—Income and Principal Account Liabilities and Capital—To Exhibit A		386,984.34

STATEMENT OF INCOME, EXPENSES AND APPROPRIATIONS
For Year Ended December 31, 1968
CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT D

Income			
Investments—General			
Bonds			
United States Government and municipals	1,309.85		
Others	3,395.03	4,704.88	
Stocks			
Preferred	466.25		
Common	13,423.84	13,890.09	
Interest on special savings accounts—The Savings Bank of Baltimore		1,357.57	
		19,952.54	
Less—agency fees	859.40		
brokers fees	1,876.10	2,735.50	
Net income—Exhibit F		17,217.04	
Investments—Eugene F. Cordell Fund—Exhibit F			
Stocks			
Common	461.60		
Less—agency fee	27.70	433.90	17,650.94
Interest on savings account—The Savings Bank of Baltimore—Exhibit F			537.39
			18,188.33
Expenses and Appropriations—Exhibit F			
Library purposes		10,881.65	
General Fund purposes		4,807.34	
Lectureship		481.80	
Cordell Fund		825.00	16,995.79
Excess of Income Over Expenses and Appropriations—To Exhibit E			1,192.54

STATEMENT OF CAPITAL
For Year Ended December 31, 1968
CONSOLIDATED FUND—INCOME ACCOUNT

January 1, 1968—Balance—Exhibit F	39,302.44
Addition	
Excess of Income over expenses and appropriations—for year ended December 31, 1968—Exhibit D	1,192.54
December 31, 1968—Balance to Exhibits A-1 and F	40,494.98

STATEMENT OF RECEIPTS, EXPENSES AND BALANCES
For Year Ended December 31, 1968
CONSOLIDATED FUND—INCOME ACCOUNT

EXHIBIT F

Fund	Distributive Share (Percent)	Balance January 1, 1968	Income Received During Year			Balance January 1, 1968 Plus Receipts	Expenses				Balance December 31, 1968	
			Savings Account Interest	Investment Income (Distributive Share)	Investment Income (Direct)		Library	Transferred to General Fund (Exhibit B)	Lectureship	Other	Cash Investments and Dividends Receivable	Cash on Deposit
Baker	.65	11.36		98.50		109.86	15.00				94.86	
Barker, Lewellys F.	.39	6.82		59.10		65.92	30.00				35.92	
Bowen, Josiah S.	9.17	160.25		1,389.67		1,549.92		1,646.21			(96.29)	
Bressler, Frank C.	1.80	31.46		272.78		304.24		323.14			(18.90)	
Cordell, Eugene Fauntleroy	3.64	21,206.37	537.39	551.63	433.90	22,729.29				825.00	21,904.29	12,965.15
Cowles, Nellie N.	.75	949.10		113.65		1,062.75					1,062.75	
Ellis, Charles M.	—	—		2,062.50		2,062.50		2,062.50				
Finney, John M. T.	8.40	5,997.70		1,272.98		7,270.68	1,346.75		190.05		5,733.88	
Frick, William F.	15.02	262.47		2,276.21		2,538.68	2,696.39				(157.71)	
Friedenwald, Julius F.	.75	13.11		113.65		126.76		134.64			(7.88)	
Harlan, Herbert	.76	224.46		115.18		339.64	44.50				295.14	
McCleary, Standish	.75	13.11		113.65		126.76	91.29				35.47	
Osler Endowment	1.40	206.48		212.17		418.65	9.00				409.65	
Osler Testimonial	7.75	3,337.69		1,174.47		4,512.16	411.95	236.93			3,863.28	
Ruhrah, John	40.79	2,077.66		6,181.58		8,259.24	6,084.57				2,174.67	
Stokes, William Royal	3.09	822.18		468.27		1,290.45	152.20				1,138.25	
Trimble, Isaac Ridgeway	2.64	3,942.90		400.08		4,342.98			291.75		4,051.23	
Woods, Hiram	2.25	39.32		340.97		380.29		403.92			(23.63)	
	100.00	39,302.44	537.39	17,217.04	433.90	57,490.77	10,881.65	4,807.34	481.80	825.00	40,494.98	12,965.15
		To Exhibit E		Totals To Exhibit D				Totals To Exhibit D			To Exhibit E	To Summary

SUMMARY—To Exhibit A-1

Cash		
Individual Accounts—above	12,965.15	
Special Account	19,018.65	
Dividends Receivable	2,190.41	34,174.21
Cordell Fund		
Cash	299.09	
Investments	8,598.54	8,897.63
		43,071.84
Less—Accounts payable to Other Funds		2,576.86
		40,494.98

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT G

CONSOLIDATED FUND—PRINCIPAL ACCOUNT

Fund	*Purpose*	*Balance January 1, 1968*	*Net Profit on Security Sales*	*Balance December 31, 1968*
Baker	Book on Materia Medica	1,402.97	.53	1,403.50
Barker, Lewellys F.	Library	841.79	.32	842.11
Bowen, Josiah S.	General	19,751.15	7.54	19,758.69
Bressler, Frank C.	General	3,876.21	1.49	3,877.70
Cordell, Eugene Fauntleroy	Relief of Widows and Orphans	7,840.82	2.99	7,843.81
Cowles, Nellie N.	Books on Neurology	1,616.84	.62	1,617.46
Ellis, Charles M.	General	8,258.46	...	8,258.46
Finney, John M. T.	Books, journals, and lectureships on surgery	18,082.12	6.91	18,089.03
Frick, William F.	Maintenance of Frick Library and purchase of books and journals	32,340.79	12.35	32,353.14
Friedenwald, Dr. Julius	Maintenance of Friedenwald Room	1,616.85	.62	1,617.47
Harlan, Herbert	Books on Ophthalmology	1,640.28	.63	1,640.91
McCleary, Standish	Lectureships and books on Pathology	1,616.85	.62	1,617.47
Osler—endowment	Permanent endowment for library by request of Dr. Osler	3,010.29	1.15	3,011.44
Osler—testimonial	Medical books and maintenance of Osler Hall	16,685.28	6.37	16,691.65
Ruhrah, John	Library books, journals, etc.	87,837.18	33.55	87,870.73
Stokes, William Royal	Lectureships and books on Bacteriology or Pathology	6,660.96	2.54	6,663.50
Trimble, Isaac Ridgeway	Lectureship only	5,688.20	2.17	5,690.37
Woods, Hiram	General	4,853.85	1.85	4,855.70
		223,620.89	82.25	*223,703.14
			Total from Schedule G-1	* To Exhibit A-1

STATEMENT OF SECURITIES SOLD
During the Year Ended December 31, 1968

EXHIBIT G-1

CONSOLIDATED FUND—PRINCIPAL ACCOUNT

Par Value Shares or Rights	*Description*	*Amount Received*	*Cost*	*Profit or Loss*
	Bonds			
1,000	United States Government Treasury Bonds—2½%—due September 15, 1972	871.25	865.00	6.25
	Stock Rights			
240	Baltimore Gas and Electric Company	39.72	....	39.72
	Fractional Shares			
750/1,000	Maryland Cap Corporation	27.16	....	27.16
200/1,000	Shulton, Inc.	9.12	....	9.12
		947.25	865.00	*82.25
				*To Exhibit G

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT H

FUNDED RESERVE

INCOME ACCOUNT

January 1, 1968—Balance		2,756.66
Additions		
Dividends	701.40	
Interest—United States Government Bonds	62.50	
—Savings accounts	112.95	876.85
		3,633.51
Deductions		
Agency fee		45.84
December 31, 1968—Balance—To Exhibit A-2		3,587.67

PRINCIPAL ACCOUNT

January 1, 1968—Balance	12,930.68
Addition	
Sale of stock rights	54.61
December 31, 1968—Balance—To Exhibit A-2	12,985.29

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT I

HARVEY G. BECK—LECTURESHIP FUND

INCOME ACCOUNT

January 1, 1968—Balance		1,077.00
Additions		
Dividends	196.80	
Interest—savings account	51.74	248.54
		1,325.54
Deductions		
Agency fee	11.80	
Reimbursement to general fund for expenditures	100.00	111.80
December 31, 1968—Balance—To Exhibit A-3		1,213.74

PRINCIPAL ACCOUNT

January 1, 1968—Balance	2,079.10
No changes during year ended December 31, 1968	.....
December 31, 1968—Balance—To Exhibit A-3	2,079.10

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT J

JESSE C. COGGINS—LECTURESHIP FUND

January 1, 1968—Balance	5,296.91
Addition	
Interest—savings account	213.80
	5,510.71
Deduction	
Reimbursement to general fund for expenditures	243.35
December 31, 1968—Balance—To Exhibit A	5,267.36

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT K

AMOS KOONTZ—MEMORIAL FUND

PRINCIPAL ACCOUNT

January 1, 1968—Balance	2,665.96
Addition	
Interest on savings account	121.98
December 31, 1968—Balance—To Exhibit A-5	2,787.94

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT L

EDUCATIONAL FUND

PRINCIPAL ACCOUNT

January 1, 1968—Balance		66,825.72
Additions		
Investment income	2,772.99	
Participants payments	13,871.46	
Contributions	7,500.00	
Aspect of sports seminar ticket sales	680.28	24,824.73
		91,650.45
Deductions		
Public relations and educational expenses	1,207.64	
Medic network	30,551.32	
Measles program	34.20	
Aspect of sports seminar	1,223.96	33,017.12
December 31, 1968—Balance—To Exhibit A-6		58,633.33

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT M

MEDICAL ANNALS FUND

January 1, 1968—Balance	1,279.99
Addition	
Interest on savings account	51.40
December 31, 1968—Balance—To Exhibit A	1,331.39

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT N

LEWIS H. STEINER FUND

INCOME ACCOUNT

January 1, 1968—Balance		9,461.38
Additions		
Investment income	13,404.18	
Interest on savings account	657.83	14,062.01
		23,523.39
Deductions		
Agency fees	730.51	
Reimbursement of general fund for purchase of library books	8,210.66	8,941.17
December 31, 1968—Balance—To Exhibit A-7		14,582.22

PRINCIPAL ACCOUNT

January 1, 1968—Balance	383,585.95
Deduction	
Loss on sale of securities	15,625.51
December 31, 1968—Balance—To Exhibit A-7	367,960.44

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT O

PLANT FUND

January 1, 1968—Balance	746,926.33
Addition	
Assessments	21,175.00
December 31, 1968—Balance—To Exhibit A	768,101.33

STATEMENT OF CAPITAL
For Year Ended December 31, 1968

EXHIBIT P

MED-CHI INSURANCE TRUST FUND

January 1, 1968—Balance—(Deficit)			(8,156.43)
Deductions			
Receipts			
Membership Premiums Collected			
Accident, sickness and total disability, etc.	287,748.61		
Blue Cross and Blue Shield	260,621.52		
Business overhead and disability	28,850.62	577,220.75	
Retirement program		7,687.50	
Administration fees		26,334.05	
Interest on securities		3,973.87	
		615,216.17	
Disbursements			
Premiums to various insurance companies	577,220.75		
Administrative and Clerical Services	11,270.00		
Fees—legal	5,807.50		
—consulting	4,325.08		
Postage, stationery and supplies, etc.	2,422.94	601,046.27	
Excess of receipts over disbursements			14,169.90
December 31, 1968—Balance—To Exhibit A			6,013.47


SIGILL · MENSE · JUNII · A · D · 1799 & LIBERT · AMERIC · 23to
TERRÆ MARIÆ
CHIRURG
SOC · MED ·
INSTITUT ·
ΠΟΛΛΩΝ ἈΝΤΑΞΙΟΣ ἈΛΛΩΝ



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time . . .
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynadiol diacetate 1 mg., mestronol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a post history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	*Mortality Rates*		*Hospitalization Rates (Morbidity)*
	Age 20-34	*Age 35-44*	*Age 20-44*
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The lang-range effect an the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenarrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



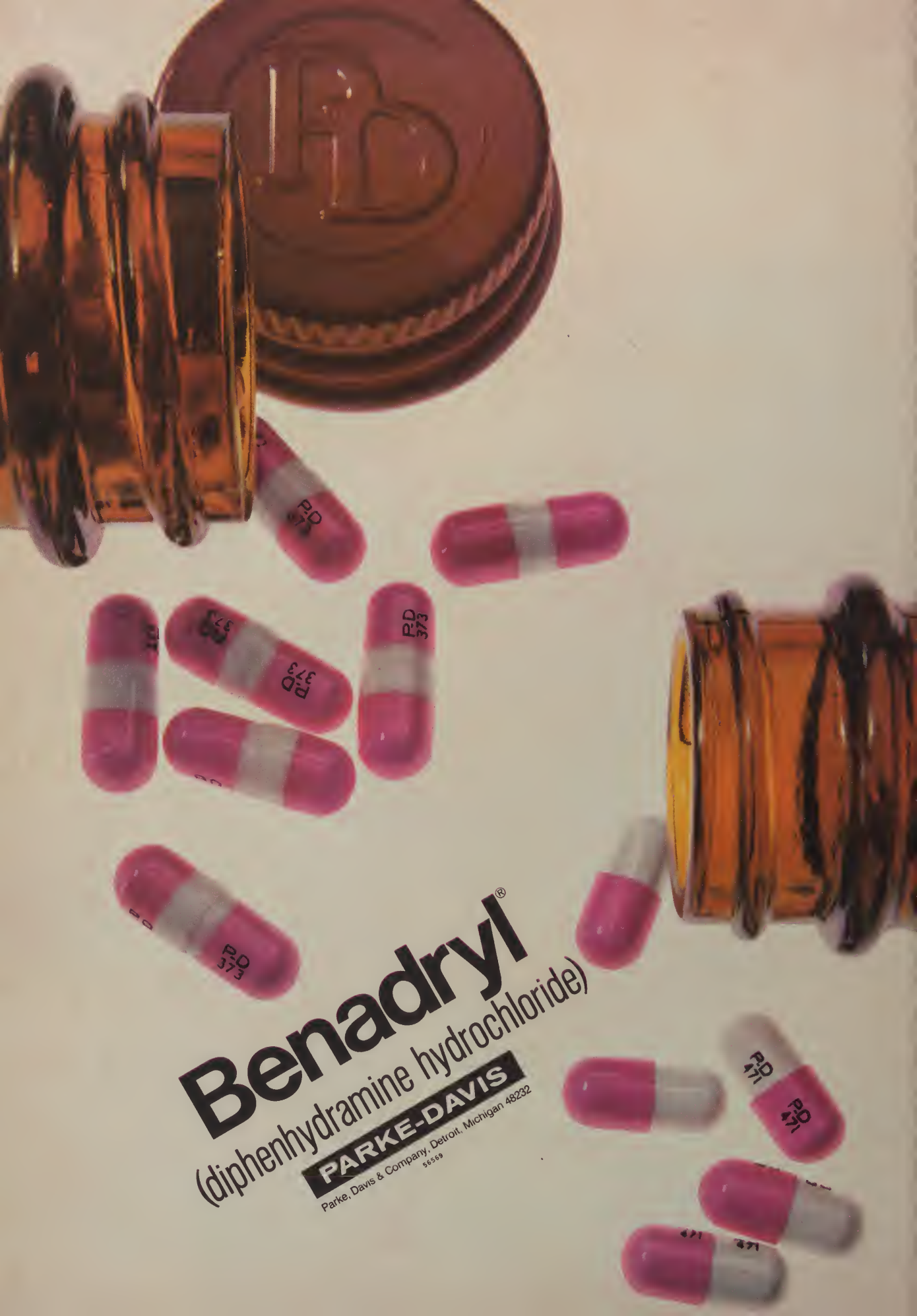
References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE

972


Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
56569

Does your patient have periods of unconsciousness or amnesia?

RUTH W. BALDWIN, MD

Director

Clinic for Exceptional Child

University of Maryland Dept. of Pediatrics

School of Medicine

Periods of unconsciousness or amnesia may be due to

- Hypoglycemia related to insulin reactions, pancreatic cysts or tumors
- Epilepsy—petit mal, grand mal, focal, psychomotor
- Sensitive carotid sinus
- Hypocalcemia
- Parathyroid deficiency
- Central nervous system degeneration
- Emotional upset
- Syncopy
- Cardiovascular disorders

If any of the above are fully controlled in a responsible individual, he should be able to drive without difficulty. However, the individual who refuses to accept the diagnosis that he has one of the above, or who is careless about his medical treatment should not be allowed to operate a motor vehicle. In order to gain an operator's license, many patients who have been denied the privilege to operate a motor vehicle have taken better care of their health, followed their physician's instructions and advice and, thus, have not only gained their permits, but also have learned the benefits of better medical treatment.

So, advising your patients not to drive if any of the above uncontrolled conditions are present, may not only prevent an accident which could result in death, severe injury, or damaged property, but may be the incentive for him to follow your advice and instructions for better health and life.

From the Subcommittee on Traffic Safety of the Medical and Chirurgical Faculty of the State of Maryland

"I'm sick of spinning"



When vertigo began, her life took a turn for the worse.
Either she spins and the room stands still,
or the other way around... and around and around.
Even when she lies down, the spinning
continues. Sometimes there's nausea and vomiting, too.
It's just one thing after another.

You can help stop the spin with

BONINE®

(MECLIZINE HCl)

Bonine protects most patients against vertigo and nausea up to 24 hours with a single dose. Pleasant-tasting Bonine tablets are chewable and can be taken anytime, anywhere, without water. In difficult cases, multiple daily doses may be necessary for maximum response.

Precautions: Although the incidence of drowsiness and atropine-like side effects such as dry mouth and blurring of vision is low, the physician should alert the patient to the need for due precautions when engaging in activities where alertness is mandatory. *Use in women of childbearing age:* In weighing potential benefits vs. risk in women of childbearing age, consider the fact that a review of available animal data reveals that meclizine exerts a teratogenic response in the rat. In one study a dose of 50 mg./kg./day (50 times the maximum recommended human dose) produced cleft palate in 2 of 87 fetuses when administered to the rat at critical times during the first 15 days of gestation. At doses of 125 mg./kg./day, meclizine will produce 100% incidence of cleft palate in the rat. At doses of 25 mg./kg./day, decreased calcification of the vertebrae and relative shortening of the limbs were also produced in the rat, but experts disagree as to whether this is a teratogenic response. While available clinical data are inconclusive, scientific experts are of the opinion that this drug may possess a potential for adverse effects on the human fetus. Consequently, consideration should be given to initial use of a nonphenothiazine agent that is not suspected of having a teratogenic potential. In any case, the dosage and duration of treatment should be kept to a minimum.
Supply: 25 mg. scored tablets.
More detailed professional information available on request.

Pfizer
LABORATORIES DIVISION
New York, N.Y. 10017

MEDICAL NEWS

The Signing of Senate Bill 149:

Photo by Stuart Whelan



Senate Bill 149 was enacted into law on July 1st of this year. This bill stipulates that individuals may incorporate and take advantage of tax situations that previously were not available to professional persons. Signers of the bill are (from left): Senator William James, President of the Maryland Senate; Governor Marvin Mandel; and Thomas Hunter Lowe, Speaker of the House of Delegates. Witnesses include: James Poland, OD, President of the Maryland Optometric Association; W. Manning Alden, MD, Vice-President of the Council of the Medical and Chirurgical Faculty; Arnold Feldman, DDS, Secretary of the Maryland State Dental Association, and Manley Davis, Esq., Executive Director of the Maryland State Bar Association.

The Johns Hopkins University School of Medicine has received a Commonwealth Fund grant of $280,000 to continue its assistance to the development of the medical schools of the American University of Beirut (AUB), Lebanon, and the Peruvian University Cayetano Heredia, Lima.

At both AUB and the Peruvian school, Hopkins has concentrated on building up postdoctoral education. The program has been conducted through exchange visits of senior faculty, and postdoctoral education at Hopkins for prospective young teachers from the overseas schools. Thus far, nine Hopkins professors and seven foreign professors have taken part, and fourteen postdoctoral fellows have been sent to Hopkins.

Hopkins' work with AUB has been coordinated by **Samuel P. Asper, Jr., MD,** Associate Dean for Postdoctoral Education, while **A. McGehee Harvey, MD,** Director of Hopkins' Department of Medicine, has organized the collaboration with the Peruvian University Cayetano Heredia in Lima.

* * *

On June 5, 1969, **William B. Kouwenhoven, PhD,** professor emeritus of electrical engineering at The Johns Hopkins University, received an honorary degree of Doctor of Medicine at The Johns Hopkins commencement exercise. The award is unique in that it is the first honorary degree to have been given at Johns Hopkins, and it is believed that only one or two other persons have ever received it from an American university.

Dr. Kouwenhoven is known for his work in developing two methods of treating fibrillating hearts. These are the external heart massage and use of electrical defibrillators, which have saved the lives of hundreds of persons after heart attacks.

Dr. Kouwenhoven was dean of the Hopkins School of Engineering from 1938 until his retirement in 1954. Presently, he is a lecturer in surgery at The Johns Hopkins School of Medicine.

* * *

J. M. Sanchez, MD, has been accepted as a fellow member in the American College of Surgeons.

* * *

Leon L. Mann, MD, James A. Prichard, MD, and David Symmes, PhD, from the Behavioral Biology Branch, National Institute of Child Health and Human Development, Bethesda, Maryland, received the Second President's Award for their paper, "EEG, EKG, and Acid-Base Observations During Acute Fetal Hypoxia." The Award, given for the best papers presented at the fall 1968 District Meetings by Fellows or Junior Fellows, was presented at the Business Session of the 17th Annual Clinical Meeting of the American College of Obstetricians and Gynecologists.

* * *

The Higher Education Loan Program (HELP) of the American College of Obstetricians and Gynecologists has $153,000 ready to be loaned out.

The loans are made to residents in approved obstetric-gynecologic training programs, interns already accepted for such a residency, and physicians in the first year of ob-gyn practice who have completed their residencies.

For further details, write: The American College of Obstetricians and Gynecologists, 79 West Monroe St., Chicago, Ill. 60663.

* * *

On June 17, 1969, **the Professional Forum** observed its Fourth Anniversary with a dinner and a series of seminars at the Baltimore Country Club. Established in June 1965 for the purpose of communication with all of the disciplines, members of the organization are drawn from accounting, dentistry, law, medicine, engineering, the clergy, the academic community, and the social sciences.

Presently, plans are being made to establish a Committee on Architecture. When these are completed, the all-male organization will have achieved its goal of being the only group in the United States representing all of the professions.

* * *

The American Medical Association's Speakers Program has been awarded a Golden Trumpet Award in competition sponsored by the Publicity Club of Chicago. The award cites the Speakers Program as the best public relations special program conducted by a non-profit organization during the past year.

* * *

Governor Marvin Mandel has announced the appointment of **Neil Solomon, MD,** to the newly created cabinet-level post of Secretary of Health and Mental Hygiene.

Dr. Solomon has been serving since February as the Health and Scientific Advisor to the Governor, having taken leave of absence from his positions at the University of Maryland, Baltimore City Hospitals, and The Johns Hopkins University.

* * *

Solomon C. Goldberg, MD, assistant chief of the Psychopharmacology Research Branch of the National Institute of Mental Health (NIMH), Chevy Chase, shared with two former NIMH scientists the Lester N. Hofheimer Prize for Research, conferred at the recent 125th anniversary meeting of the American Psychiatric Association at Bal Harbour, Florida.

Winners of the prize were cited for their collaborative research, under the auspices of the Psychopharmacology Research Center of the NIMH, in delineating the positive and negative effects of phenothiazines on various aspects of schizophrenic illness, and in correlating the symptom profiles of patients with the degree of response to drug treatment.

* * *

Frank J. Ayd, Jr., MD, internationally known lecturer, writer, and psychiatrist from Baltimore, was awarded the honorary degree of Doctor of Laws at Mount Saint Mary's College commencement exercises on June 1, 1969.

Dr. Ayd received his medical degree from the University of Maryland School of Medicine in 1945. In 1951, the American Board of Psychiatry and Neurology certified him as a Diplomate in Psychiatry. He has lectured in Europe, Asia, Africa, the Orient, Australia, New Zealand, and North America. Dr. Ayd has published more than 200 scientific articles, has contributed to more than 30 books, and is editor and publisher of several newsletters.

* * *

William M. Gatewood, MD, chief radiologist at Harford Memorial Hospital, has been elected President of the Maryland Radiological Society.

After graduating from the University of Virginia in 1950 with a BA degree, Dr. Gatewood entered the University of Louisville Medical School, where he received his medical degree in 1956.

* * *

A nucleus of physicians, both from full-time and part-time emergency care groups in Michigan, chartered the **American College of Emergency Physicians** and have organized the college on a nation-wide basis.

The college has been formed in recognition of the need for a new type of physician, a specialist in emergencies: the Emergency Physician. One of the main purposes of the college is to improve emergency services rendered to the patient.

* * *

The American Medical Association has announced the formation of an ad-hoc committee whose purpose is to establish a **National Society of Police and Fire Surgeons.** For further information write to: Howard Schneider, MD, Chairman, 75 Lee Ave. (at Mclean) Yonkers, New York 10705.

* * *

Dean David Rogers, of The Johns Hopkins University, traveled to Italy as part of a survey team to attend a conference on Italian Medical Education, sponsored by the Josiah Macy, Jr. Foundation.

* * *

Harriet L. Haskins, MD, of the department of environmental medicine, has been promoted to the rank of Associate Professor at The Johns Hopkins University.

* * *

Appointed to the rank of Professor at The John Hopkins University School of Medicine is **George H. Connor, MD,** department of laryngology and otology, and **Richard T. Johnson, MD,** neurology. In neurology also, **Daniel B. Drachman, MD, John M. Freeman, MD, and Robert M. Herndon, MD,** were appointed to the rank of Associate Professor.

* * *

Mr. and Mrs. Harry Waller have donated $50,000 to The Johns Hopkins University School of Medicine to establish in their names the Anne and Harry Waller Fund for the partial support of a Samuel Livingston Scholarship in Epilepsy Research.

Samuel Livingston, MD, is an Associate Professor of pediatrics and Director of the epilepsy clinic at Johns Hopkins.

* * *

John B. Imboden, MD, has been appointed Psychiatrist-in-Chief at Sinai Hospital and assumed his duties at the hospital in the beginning of the summer.

Dr. Imboden received his MD from The Johns Hopkins University School of Medicine in 1950. Currently, he is in private practice and is supervisor of residents in psychiatry at The Johns Hopkins Hospital, Sheppard and Enoch Pratt Hospital, and the Veterans Administration Hospital at Perry Point.

* * *

William A. Holbrook, MD, and James T. Estes, MD, have announced their association in the practice of Vascular Surgery at the Washington Hospital Center, the Physicians Office Building in Washington, DC.

* * *

Charles D. Connor, MD, was certified in both Anatomical and Clinical Pathology in May 1968, and was elected a Fellow of the American Society of Clinical Pathologists in the same year. In May 1969, Dr. Connor also was elected a Fellow in the College of American Pathologists.

* * *

A Two-year grant of $121,600 from the W. K. Kellogg Foundation will aid the **Association of American Medical Colleges** (AAMC) to develop an educational program for business officers in the nation's medical schools. The project is a logical sequence to previous assistance to the association by the founda-

tion for the improvement of cost accounting and management at these institutions.

* * *

Samuel P. Asper, MD, of Baltimore, was installed as President of the American College of Physicians at the College's 50th Annual Session at the Conrad Hilton in Maryland in April 1969.

Dr. Asper, Associate dean and professor of medicine at The Johns Hopkins University School of Medicine, succeeds H. Marvin Pollard, MD, of Ann Arbor, Michigan, as head of the international society for nearly 15,000 specialists in internal medicine and related specialities.

* * *

A vision screening program to find children living in Northeast Baltimore who may require diagnostic, preventive, or corrective treatment was held in April 1969 at the Telephone Pioneers Activities Center in Baltimore.

The community service program is sponsored by the Maryland Chapter, Telephone Pioneers of America, with the assistance of the Maryland Society for the Prevention of Blindness, a United Appeal agency.

* * *

Edward M. Holmes, Jr., MD, MPH, has been named Director of the Medical Center's Rehabilitation Programs and the Rehabilitation Research and Training Center, and Professor in the Department of Public Health and Epidemiology at the University of Alabama.

Dr. Holmes received his medical degree from Georgetown University. He was awarded his MPH from The Johns Hopkins School of Hygiene and Public Health.

* * *

The Senate Finance Committee has considered, and subsequently adopted, a bill which would repeal the medicaid provision in existing law which prohibits the Secretary of HEW from approving a Title 19 state plan that results in a reduction of any of its public assistance programs.



George E. Schreiner, MD, (right), international authority on medical and surgical care, Professor of Medicine at Georgetown University, and President of the National Kidney Foundation, presented a renewal charter for service to Edward J. Hinman, MD, President of the Kidney Foundation of Maryland, during a meeting of the Maryland trustees of the Kidney Foundation held in Baltimore.

* * *

The effect of this change will be that states can reduce the scope of some of their public assistance programs and still receive federal financial assistance. The bill will also repeal the requirement in existing law that the state must provide, by 1975, comprehensive care and services to substantially all individuals who meet the eligibility requirements of state plans with respect to income and resources.

* * *

The Obstetrics and Gynecology Specialty Group of the International College of Surgeons has announced a competition for an award to be given the author of a manuscript selected by the Prize Committee of the Group. This award will consist of an invitation to present the winning paper at their meeting in Paris, France, April 20-24, 1970, including a round-trip ticket, hotel expenses, and $10 per diem.

For further information, write to: Abraham F. Lash, MD, Chairman, International College of Surgeons. United States Section, 1516 Lake Shore Drive, Chicago, Ill. 60610.

* * *

William F. Towle, assistant administrator of The Johns Hopkins Hospital, has been named administrator of the organization that will plan, build, and operate the hospital and clinics in Columbia, Md.

The announcement was made by the trustees and officers of Columbia Hospital and Clinics Foundation, Inc. The Foundation is a corporation of The Johns Hopkins University and The Johns Hopkins Hospital, which are establishing a voluntary, comprehensive, prepaid health care program for Columbia residents.

Mr. Towle, who has been a resident of Columbia since last fall, opened administrative offices in the new city in June.

* * *

Gustavo A. Lugo, MD, former fellow in pediatric cardiology

at The Johns Hopkins Hospital, has joined the faculty at the University of Alabama as instructor in pediatrics.

* * *

At the 122nd Annual Meeting of the American Psychiatric Association, which was held last May in Miami, Florida, a way to reverse the increasing national dependence of the emotionally disturbed and mentally ill on "outside help and intervention" was offered by an Indianapolis psychiatrist.

Hanus J. Grosz, MD, said the secret is a national self-help organization known as Recovery, Inc. During a unique evening session, Dr. Grosz introduced members of the organization—each a nervous or former mental patient—who demonstrated their group techniques before the assembled psychiatrists.

* * *

The Johns Hopkins Hospital has named **B. Harvey Minchew, MD,** an official of the federal Food and Drug Administration, to head the internal medicine section at its planned Columbia health center.

Dr. Minchew, 37, who will become an assistant professor of medicine at the medical school, joined the FDA in 1963 and became deputy director of the Bureau of Medicine in January 1967.

* * *

The chairman of the AMA Committee on Alcoholism and Drug Dependence estimated that 5% of U.S. college students have tried LSD and 20% of high school and college-age youths have experimented with marihuana and other hallucinogenic drugs.

The chairman, Henry Brill, MD, of West Brentwood, Long Island, N.Y., made the estimate in testimony before the Senate Health Subcommittee.

"And," he added, "although no accurate count has been made, there are signs that the abuse of heroin and other so-called 'hard' narcotics is spreading into the suburbs."

Dr. Brill told the subcommittee that the nation's physicians increasingly "are being called upon to treat patients with drug problems, and to give counsel to anxious and bewildered parents who are discovering that 'it can happen' to their sons and daughters."

He emphasized the need for more research in the narcotics field.

* * *

Med-Chi's Councilors

Charles H. Ligon, MD, D. Frank Kaltreider, MD, and **Philip Franklin Wagley, MD,** have been elected Councilors of the Medical and Chirurgical Faculty of the State of Maryland.

Dr. Ligon, a Councilor from the South Central District, received his MD in 1942 from The Johns Hopkins School of Medicine. Since 1947 he has been in private practice as a general practitioner and surgeon, and he is an active staff member of Montgomery General Hospital in Olney, Maryland. Dr. Ligon also is an active member in the Montgomery County Medical Society, The Johns Hopkins Medical and Surgical Society, and various community organizations in which he has held many offices. Previously, he has held various positions in the Medical and Chirurgical Faculty, including Delegate, Vice President, and President.

* * *

Dr. Kaltreider, a Councilor from the Central District, received his AB degree from The Johns Hopkins University, and his MD from the University of Maryland School of Medicine in 1937. He completed his postgraduate training at University of Maryland Hospital and Baltimore City Hospitals. Presently, Dr. Kaltreider is a professor of obstetrics and gynecology at the University of Maryland Medical School, and chief of the Department of Obstetrics and Gynecology at the Baltimore City Hospitals. He holds membership in numerous organizations, and still finds time to involve himself in research activities which have resulted in the publication of over 40 papers in various medical journals.



Dr. Kaltreider

* * *

Dr. Wagley, a Councilor for the Central District, graduated from The Johns Hopkins School of Medicine in 1943 as a Franklin P. Mall Scholar in Anatomy. He is affiliated with various organizations, including the American College of Physicians, the

American Medical Association, and the American Society of Internal Medicine. Dr. Wagley has also published many papers, whose subjects range from neurophysiology to enzymology. At present, he is engaged in the practice of internal medicine, teaching, and clinical research.



Dr. Wagley

* * *

Highlights of Annual Meeting



Russell S. Fisher, MD, (left), the Faculty's new President, accepts the gavel from Arthur G. Siwinski, MD, outgoing President, during the Annual Presidential Banquet held in April in Baltimore.

THE PRESIDENTS . . .



Dr. Siwinski congratulates Richard D. Bauer, MD, immediate Past-President, during the presentation of the Past-President's plaque at the banquet.

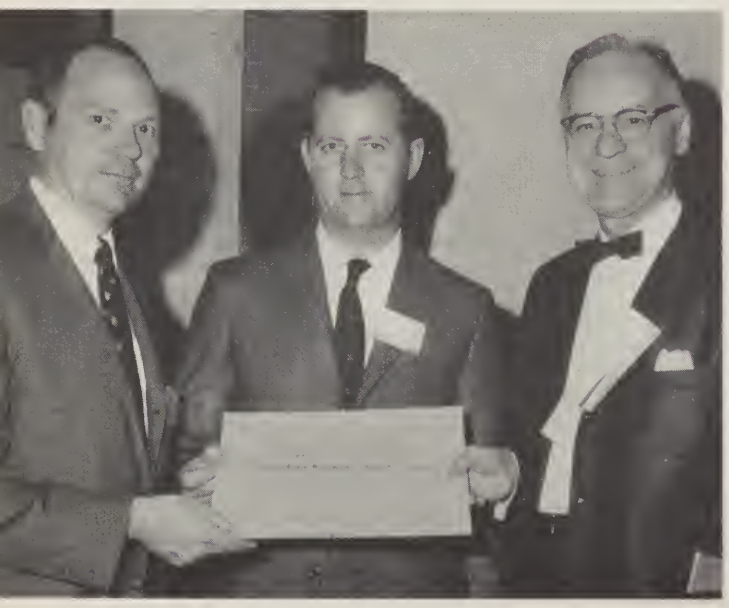
AWARDS...



At left: William S. Stone, MD, former Dean of the University of Maryland School of Medicine, proudly displays the engraved scroll bearing the resolution presented to him by the Faculty on the occasion of his retirement as Dean. Dr. Stone was cited for his contribution in raising the educational standards of the School of Medicine; for his long and distinguished career, and for his outstanding ability in all fields of endeavor. The resolution was read during the House of Delegates meeting in April.



At Right: The 1969 recipient of the Community Service Award is Gunther D. Hirsch, MD, of Havre de Grace. Dr. Hirsch was cited for his broad community interests including everything from adequate sewage disposal to music and cultural activities. Dr. Siwinski presented the Community Service Award to Dr. Hirsch during the Annual Presidential Banquet.



At left: The Outstanding Scientific Exhibit Award this year went to Richard N. Peeler, MD, Gerald Church, MD, and DeWitt E. DeLawter, MD, for their exhibit "Coronary Care in Small Community Hospitals without House Staff."

In attempting to describe the responsibilities and areas of competence of the psychiatrist, one is tempted to simplify the task by creating the best possible image for the profession, and by avoiding controversial issues. To do so, however, would not only be an insult to the intelligence of a sophisticated audience, but would hardly advance the purposes of promoting interdisciplinary relationships.

WALTER WEINTRAUB, MD
The Psychiatric Institute
University of Maryland School of Medicine

WHAT IS A PSYCHIATRIST

Fifty years ago my assignment would have been a relatively easy one. Then, most psychiatrists worked in large public hospitals. Preoccupied with the problems of diagnosis and classification, they were modest in their therapeutic aims; basic psychiatric research at that time was pursued with the hope and expectation that the anatomicopathological basis of mental illness would soon be discovered.

If, at the turn of the century, the treatment of emotionally ill people left much to be desired, psychiatrists could derive considerable satisfaction from the fact that after two centuries of struggle, French and German clinicians had made the study of mental illness the province of the physician rather than that of the philosopher and theologian.

This moment of medical triumph was to be short-lived. Two World Wars, and the remarkable permeability of American institutions to Freudian theory and practice, loosened psychiatry from its insecure medical moorings and brought the psychiatrist out of the mental hospital into the community. In an ironic twist of fate, psychiatrists began to apply Freud's discoveries to the understanding of philosophical systems and their creators, and to teach priests, ministers, and rabbis how to talk to members of their congregations.



How is the American psychiatrist educated and what is he trained to do?

Until the completion of his internship, the education of the future psychiatrist is identical with that of all physicians. This means that the bulk of his undergraduate courses have been taken in the physical and biological sciences. His knowledge of history and philosophy is limited, and only rarely is he fluent in a classical or modern European language. It is also unfortunately true that he frequently cannot speak or write his mother language with precision and style. The American psychiatrist is, therefore, not a broadly educated person. In my judgment, much of his difficulty in working with non-psychiatrists stems from this lack of a genuine liberal arts education, rather than from shortcomings in his medical and psychiatric training.

In medical school, our future psychiatrist spends most of his time digesting huge quantities of applied scientific information. Patients are presented to him as impersonal objects to be examined, diagnosed and manipulated. That many physicians never quite outgrow this attitude towards sick people is common knowledge. It must be emphasized, however, that the ability to depersonalize patients enables the medical student and the young physician to carry out vital clinical assignments which would otherwise cause them unbearable pain.

After a one-year internship during which the attitudes assimilated in medical school are reinforced, psychiatric residency begins. In most modern training centers, the young resident is profoundly shaken by an entirely new set of expectations. All his previous medical training has conditioned him to deal with anxiety by acting decisively, giving orders, and exploiting patients' faith in his omnipotence. He soon finds these defenses to be brittle indeed.

In many centers the fledgling resident is immediately assigned extremely disturbed patients with whom he is expected to spend long periods of time in individual psychotherapy. Inexperienced though he may be, he is expected early in his psychiatric residency to assume medical leadership and coordinate teams of experienced nurses, psychologists, and social workers. If, when faced with these cumulative stresses, the young resident begins to act like his patients, he discovers that only one course of action is acceptable to his colleagues and supervisors. He is expected, through a prolonged and intensive period of psychoanalysis, to uncover and resolve the conflicts causing his anxiety.

The resident who survives this Spartan regime and completes the three years of required training, emerges with a variety of useful skills. The well-trained clinical psychiatrist is equipped to assess, by means of interviewing techniques, the over-all psychological functioning of emotionally disturbed persons. He is often able, through techniques of interviewing and physical examinations, to distinguish between somatic and psychological disability. Most important of all, he is able to offer help to individuals suffering from a wide range of psychiatric illnesses. Although individual psychotherapy is still the psychiatrist's most highly developed skill, many clinicians are experimenting with various forms of group and family therapy. Recent advances in pharmacology have given the psychiatrist additional flexibility in handling certain problems.

Various types of subspecialty training are often pursued by psychiatrists after the required three-year period of residency training is completed. Those who wish to devote their professional lives to the practice of psychoanalysis may seek further formal training at a psychoanalytic institute. Many psychiatrists are choosing careers in child and adolescent psychiatry, others in administrative and forensic work.

Whenever a profession takes upon itself the task of alleviating psychic misery, there is a risk that expectations will be aroused in the community that cannot possibly be fulfilled. The modest success that the psychiatric profession has had in alleviating neurotic pain has kindled the flame of hope in the hearts of many that its techniques can solve individual and group problems that are as old as the human race itself. Through a combination of naiveté and opportunism, some psychiatrists have fanned this flame. As a result, at a time when clinical services are said to be in short supply, many psychiatrists are attempting tasks for which their training and experience have ill prepared them.

When acting as consultants to social agencies, the schools, the courts, and industry, psychiatrists may offer opinions which are little more than rationalized biases. It is important for society to understand that the education of the psychiatrist does not prepare him to tamper with public school curricula, to reorganize communities, or to prevent nuclear warfare. His knowledge of history, government, philosophy, and economics is far too limited. It is important for psychiatrists to realize that commiting their profession to a certain point of view on major issues, before a national consensus has been achieved, is potentially suicidal.

Collaborative efforts between psychiatrists and other professionals are likely to be more constructive and cordial if the realistic limits of the psychiatrist's knowledge and skills are clearly understood by both groups.

Presented at "Psychiatry and Law," a special program for the Judges of the Municipal Court of Baltimore City. Saturday, January 20, 1968.

CLERGY—PHYSICIAN

DIALOGUES

Edited abstracts of a series of discussions held between 1961 and 1967 at the Church of Our Savior, Baltimore, Maryland.

The particular interest and value of these discussions is that they come out of the experience of clergymen and physicians dealing with patients daily. The problems encountered are concrete, immediate, and very real to those involved. The discussions are rich in specific examples. There is a determination to make Christian concern relevant to the lives of suffering people in hospitals.

A second unique feature is that the participants are Protestants. Most such discussions are carried on by "Interfaith" groups and tend to be vague, innocuous and anemic in an attempt to reach consensus. No such consensus is reached in these discussions. Views are presented with conviction, often with passion, and represent only the opinion of the speaker at the time. There are vigorous disagreements and opinions were changed. In brief, a dialogue took place. We believe that clergy-physician dialogues (whether individual, denominational or interfaith) are of increasing relevance at a time when depersonalization and "scienticism" in patient care is on the upswing. Perhaps relevance and specificity could best be served by establishing interfaith clergy-physician groups in each hospital using case presentations and discussions.

Finally, no one considered himself an expert. These discussions are offered not as answers, because we do not think there are answers to these problems. There are only individual people in trouble, cared for by fallible physicians and clergy. This insight may give other clergy and physicians of all faiths the courage and impetus to discuss their common problems in hospital practice.

Introduction

Starting in December of 1961, a group of concerned Protestant clergy and physicians got together informally to discuss common problems in the care of hospitalized patients. The following persons participated in the discussions at different times:

Richard P. Anderson, MD
Rev. Pope F. Brock
Robert Bonnor, MD
John A. Burgess, MD
Douglas Carroll, MD
David Cowey, MD
Rev. Jon Crosby
Rev. John Denham
Rev. Herman A. Di Brandi
J. William Dorman, Jr., MD
Milton T. Edgerton, MD
Warfield M. Firor, MD
James P. Gills, MD
Rev. Donald W. Gross
Rev. Charles H. Griswold
J. Alex Haller, MD
James P. Isaacs, MD
Robert Johnson, MD
Rev. David K. Johnston
Rev. Don Libby
Philip O. Littleford (Medical Student)
James McNamee (Seminarian)
Don B. Nicholson (Medical Student)
Rev. David H. Pardoe
John Payne, MD
David Sabiston, MD
Rev. Warren Skipp
Martin Singewald, MD
Richard M. Timms, Jr. (Medical Student)
William H. Talbot, PhD
Thomas E. Van Metre, Jr., MD
Charles Patten Wilkinson (Medical Student)
J. Donald Woodruff, MD
Taylor M. Wray (Medical Student)

References to specific institutions and people have been avoided. It was thought necessary to indicate whether the speaker was clergy (Rev.) or physician (Dr.), but otherwise the identity of each participant has been protected.

Mrs. Frances Grebel patiently recorded the conversations in shorthand and typed copies for each participant.

No attempt has been made to change conversational style into literary style. Minor changes have been made in the interest of clarity.

Telling People About Death

Rev. A: I have a parishioner to whom I am devoted and who is dying of cancer. Apparently, it is throughout his body, and his physician gives him next to no hope. Yet he will not tell the man that he has this disease. His family will not tell him, but I am convinced that he knows it himself. The family will not tell him because they think he will give up hope. I would like to tell him. He might be really glad to talk about it, to share it with his family, and to know that there was some kind of victory that could be wrung out of it. He probably knows that he is dying, and yet, no one will talk to him about it.

Rev. B: Your primary ministry is to the man. Instead, everyone is talking about a case. This is no longer ministering to him.

Dr. K: I think that you should talk to the doctor, and decide together whether or not to tell him.

Rev. K: How about the family?

Dr. K: I think the patient is more important than the family.

Dr. B: Do you use the technic of joint consent? We use it in the military service. The minister and the physician will discuss the question of telling the patient. I think it is a good technic.

Rev. A: The visits that the practitioner makes to the home are less and less frequent, and the man makes comments that he must have given up. The very fact that the physician has dropped off in his visits is a sign that he has given up.

Dr. D: I think it is a very common problem. I have many patients in the hospital, and it is tough to see them when you can't do anything for them.

Rev. K: Why do we not tell the patient the situation, either the clergy or doctor? It is not just because of the concern for the patient, but partly that we are not quite sure how we are going to handle it when it is in the open.

Dr. D: I do not like to tell people that they are going to die. If they are not going to be able to face it, that is a reason not to tell them. One can do damage in making a rule to tell every patient that he is going to die. I had a patient I thought would die and told the family so, but now he is well. However, there are some you have to tell.

Dr. B: I am wondering about the area of ministering to the immediately dying. What if the family tells you not to tell him he is dying, but you do and he dies. What is the legal responsibility?

Dr. G: You cannot be sued for a mistake in judg-

ment. According to law you are not liable.

Dr. B: What is the moral responsibility?

Dr. G: If your intention was to get this man oriented spiritually before he died, I think you are right. Your motive was not selfish. The only motive is to help the man prepare for death, and I think that, morally, it is all right.

Dr. S: At times your biggest responsibility is to the family and not the patient. He may be prepared to go, but the family is not prepared to let him go.

Rev. D: I had a patient who asked whether she were dying. She was in a semi-private room with a patient whom I had been visiting. My patient pretended to write to me the address of her friend to whom she wanted me to send a copy of a sermon, but when I received the paper she had written, "The patient in the next bed is dying of cancer of the throat." I began to talk to her. I continued to see her after my patient left the hospital. She was a woman of 55, very emaciated. Last Tuesday I went in and, from a layman's point of view, I felt sure that she was dying. She asked me if she were. There were two reasons I did not say, "Yes, you are." I did not know what her doctor had told her, and I did not know how he would feel about my telling her. She was very emotional, and if I told her, I felt that her death would be more violent than otherwise. I did the best I could and said, "I do not know for sure." But I was with her when she died at 7:15 P.M. This conversation had taken place at 3:00, and she was conscious until 6:30. I had intended to find the doctor, but I could not find him, and the patient did not want me to leave her.

Dr. J: Why didn't you say, "This is something that is not in my hands. Should we approach the Lord together?" And say a prayer with her. You are being totally honest.

Rev. D: I had done that two days previously. We had prayer this time also. Her husband was reading the Bible, and I asked him to read it aloud. She felt comforted because he was there reading the Gospel according to St. John.

I thought that it might be all that night and the next day. I was quite surprised when this patient went so suddenly. Could I have complicated her death by telling her? Could it have been more violent if I had said, yes?

Dr. J: I think as a clergyman you did not have to answer the question. The patient does not expect you to know. You have the advantage of not having to answer it. In a sense the patient would excuse you for saying, "I don't know."

Dr. G: When a patient asks me if he is going to die, I almost invariably ask, "Why do you ask me?" I want to know if he is afraid to die, if there is something on his mind he wants to get off. That opens up the way for an intimate conversation. If I am not absolutely certain he will die in a few minutes, I come back to the question and say, "I am glad you asked that question. When you will die is not the first thing. Let us face the first thing, the inevitability of death. Everyone has to face it." Some mean, "Am I going to die of this disease"? Find out why he asks the question.

Dr. S: I think that the patient's mental and emotional state has a tremendous bearing upon what you say. Are you dealing with a patient who is so toxic from his illness that he is really unable to grapple with anything, or are you dealing with a patient with full faculties?

Dr. G: Both physicians and clergy have an inescapable responsibility to relieve the suffering of the dying and of the relatives. The control of pain is the full duty of the physician. Alleviation of mental anguish is the responsibility of both groups. The ministry to the spiritual needs of the patient is primarily that of the clergy, but also to a degree, that of the doctor. Rigid rules cannot be laid down, but the basic principles can be:

1. There comes a time in which it is the duty of the physician to help the patient to die comfortably.
2. Treatment designed solely to prolong existence is contraindicated.
3. The question of facing the fact of death: Generally speaking, it is preferable to break the news gently to the patient. Patients can stand anything except untruth and sustained uncertainty.
4. An absolute prognosis as to time of death is nearly always inadvisable.
5. Relatives must be given rest, particularly when death is drawn out.
6. Dying patients never like to be left alone.

From the spiritual side, the Almighty alone knows the spirit-experience and status of the individual patient. All we can hope to do is to be dedicated agents so that God can work through us in each instance. If we are really dedicated persons, what difference does it make whether we are clergymen or physicians? It is the relationship of the individual to God Almighty, and we must keep in mind that we are simply agents. This is as far as we can go.

Palliation and Allowing Patients to Die

Dr. I: One of the real problems that I have in medicine is approaching the problem of palliation, making the patient more comfortable, when there is no cure. The longer one is in medicine, the more one wants to win the game. And yet, palliation is an extremely important part of medicine. It requires far more insight than to say that this is a

cancer of the toe and take it off. The responsibility of the physician is to help a patient live with his illness and remain whole. An example would be arteriosclerosis, a generalized disease. There is no cure. And yet we are called upon often to remove an area of vascular constriction. This is a form of palliation. It may be dramatic, but it does not represent a cure. When the next area, which has already narrowed, produces symptoms, then rapport dissolves. With limitation of time, many physicians are not willing to spend time in re-establishing rapport. We have to call on the other members of the team to help. Some of this can be and should be delegated. This approach is very important.

Rev. A: Are there many surgeons who would not have the time to sit down and tell the patient about his condition, and say that this will help temporarily, but you may have a recurrence? Does a physician get so busy that he cannot discuss it?

Dr. I: Some of us find it difficult to admit that we are not perfect in our ability to heal. You feel that you should be able to relieve everything. It is a form of personal dishonesty, but all the patient requires of me is that I be honest. He doesn't expect me to be a miracle worker. The doctor thinks he is a miracle worker, but the patient does not. He expects honesty.

Rev. A: The doctor could honestly say that he could relieve the patient to a certain point, but this does not mean a cure.

Dr. I: You have to think of yourself a little. It is a little selfish, but it is not right to put yourself in the position of later saying that you could not effect a cure. If it is a chronic problem, but can be relieved, I think it is important to get this insight across. Recently, I saw a patient who had a sudden thrombosis in the leg with severe pain. It was obvious that the leg would have to come off. She was not ready to accept that. We let her go for a while, and within 36 hours she said, "You are right. I am going to have to live without my leg." And then it was removed. If I had removed it earlier she would have had all kinds of mixed emotions about a leg which might have gotten well. We gave her 36 hours of pain of which she could have been relieved. This is where it gets hard. If you don't have the time to spend with the patient, you should get someone else to help. There are some people who by nature would not want to spend that period of time to help a patient to make up his mind. You can get in trouble in medicine in having a patient who is not grateful and who does not have a good result, even after good treatment.

Dr. I: Today I saw a difficult patient who had a breast removed for cancer two years ago, and who subsequently developed spread, and now all the various kinds of medicine that are available are being used to keep the patient going. It is difficult to know when life is really life and not just an organic existence. The artificial pace maker, the various medicines that keep the blood pressure up. . . . Where does palliation become automation?

Rev. A: A great deal would depend on the individual response from the patient. In case of the young woman with cancer, is she aware of her condition and what it is likely to ultimately lead to?

Dr. I: I think she is.

Rev. A: I wonder how she is taking it.

Dr. I: She was smiling with euphoric drugs. You wonder if it is only skin deep. That is the most difficult area in medicine to know when it is no longer worthwhile continuing organic life artificially. It requires about one more year's experience than you get in your lifetime. No one wants to see his patients die. But one responsibility is to let them die comfortably, gracefully. It has gotten so you can't come into the hospital and die gracefully. One example is of a mongoloid with an I.Q. of ten and an abnormality of the duodenum. The patient cannot live without an operation. Do you operate on him? Are you penalizing the child and the family by operating on this mongol? Mongolism is a sort of unpredictable kind of condition. It is impossible at birth to be sure what the functional ability of the human being will be. You can't be sure whether it is a subnormal individual or a real idiot. For this reason it is an even more difficult decision. How do you feel about this problem?

Rev. E: It is a frightfully difficult one. It is interesting to hear some of the process you go through of whether to sustain life or not. The possibility of what the mongoloid case can be—what is the chance of being slightly subnormal?

Rev. A: Did you talk to the parents?

Dr. I: What we are really saying is what happens to so many people in medicine. You feel you are responsible. You take it upon your own shoulders as though you caused it. Then you can't be objective. You have to be objective if you give the proper advice to the parents. What has to be done, as nearly as you can judge as a trained specialist, is to tell the parents what you think the situation is, but the decision has to be theirs. You have to remain an objective advisor. You did not cause it, a birth defect or trauma. The best thing you can do is to give the parents an evaluation. This is a newborn they have been looking forward to. It is either the first child, or there has been a big gap. I think your responsibility is to get across to one of them, what the situation is. You may feel that the patient should or should not be operated on, but the decision has to be theirs. Otherwise, you take upon yourself a responsibility that I don't think is yours.

Rev. G: The clergyman is in the same position. He cannot save people.

Rev. E: A lot of clergy would say, that as long as there is hope of life, everything must be done. I don't think that I would feel that way. Just to keep somebody alive does not make sense at all.

Rev. D: I personally take a very realistic view in this same way. Just to prolong life is not the thing to do. The people involved have to make the decision. Everyone has to cooperate with them in that decision.

Dr. I: About three months ago there was a mongoloid baby born with duodenal atresia. The mother went to pieces. It was the first baby. The father said he could not take the baby home. The house staff felt very strongly that the baby should be operated on, but the father did not want him operated on. The house staff put a tube in the baby's stomach, and a cutdown needle in the veins, and gave the baby fluids for six days. They could maintain him this way. What do you do with such a patient? You can't shut the door. It is a human being. It was a very upsetting experience for the pediatric house officers. The outcome was that finally some higher up made the decision to cut off I Vs and the patient died in 48 hours.

Rev. A: In this type of situation as Christians, part of the answer for the physician or the clergyman or any Christian is to make it quite clear that God is God of all things, and that this might not put too much premium on life here and now. It is not lost even if one died. If you believed this, it might help a parent to decide to let a child die, if they felt that it was not sinful to let it die.

Dr. I: Let me suggest another aspect. Through the ages, the statement has been made about congenital heart disease: "This is an act of God. They all die." We would not have the Blalock operation today if somebody had not had the insight to alter this and say, "Let's try. Let us see if we can't save some by surgery even though the mortality may be high."

Dr. M: I would like to ask you if leaving the responsibility with the parents, they may have a burden of guilt. This could be that, "I killed that baby." In selected cases, might it not be better to make that decision yourself when you see the parents will not be able to make it?

Dr. I: Some physicians will. I won't. I don't have the total insight into what will happen in that family. There are physicians who will say, "This patient will die in six months. There is nothing more to do." They will leave the family and the clergy to work it out. I am not critical of that. I don't belong to that way of life. But what you are talking about is important. Recently, a baby was born without any eyes, with no nose, with no passageway between the nose and mouth, a large umbilical hernia, and probably internal malformation. This baby could not possibly live as it was. It could not breathe. A newborn baby cannot breathe through its mouth. They put in a little airway to breathe. They called me to operate on the abdominal situation. I was appalled. I talked with the parents. They had a sixteen-year-old son and no other children. The father said he did not want the mother to see the baby, but he wanted the baby operated on. He felt there was no problem. In a couple of years, eyes could be transplanted. You have to try to bring some reason into this. I tried. He finally saw that it would be impossible to put eyes in the baby. He said, "There's Helen Keller." He felt that plastic surgeons could do something about the nose. This family, particularly the husband, would never be able to live with himself unless every effort was made to keep the baby alive. I repaired the abdominal defect and inserted a tube for feeding. The baby died five or six hours later. The family was delighted that the baby died. There was no guilt feeling. Everything possible was done for their baby. At autopsy the baby did not have any brain. But I do not think it was a worthless night, because we now have whole parents. But it is hard to be enthusiastic about that kind of surgery. I can't apply this approach to the Mongol because I don't know what the outcome there will be.

Rev. D: Something you said about the parents having a guilt feeling . . . it takes a lot of work to build up responsibility, not only in surgery and medicine, but in other realms of life. Neurotic guilt belongs to the psychiatrist, but there is a healthy spiritual guilt that takes care of us spiritually.

Dr. I: Every congenital abnormality is accompanied by guilt on the part of the mother and father. They ask, "What did I do?"

Rev. D: The same thing with responsibility. Some lack of it is moral, some is neurotic, some is spiritual.

Dr. I: I don't have the answers. It may be, in the long run, healthier for the parents to have a deformed child and care for it and let it grow up, and let the parents have the insight into life, than to have it taken from them.

Rev. A: You get to a point where you have to deal with each individual or each family unit as an inividual proposition.

Dr. I: Every day you were taught in medical school to treat the patient as a whole person.

Rev. A: Despite a poor medical outlook, something really good may emerge from the situation. Other factors may happen that give strength, aid and comfort to such a person. Either God is absent or he is a going concern with us. At least for clergy I think this is the point where we believe, despite the fact that medically nothing more can be done.

Dr. I: A lot of physicians talk to their patients alone and tell them they have cancer. Then they will talk with the next most responsible people. I bring the family in so that there is no question about the truth. I do not say, "You have an incurable disease." But I say, "We were not able to remove all of the cancer. There will be medicine and X-ray treatment." The family won't feel uncomfortable around the patient who has an incurable disease. There are some patients whom you don't tell. By and large, the patient who has cancer knows it and you are not fooling him. If they ask me point blank, I say, "Yes," and I say what has been done and what can be done. If they don't ask, I don't tell them, but some person in that family must know.

Dr. T: How do you alter your procedures to deal with the mentally ill? It seems to me it would be impossible if they were unable to grasp anything.

Rev. D: Initially, the only thing I would do is support him if possible. I play a supportive role to the patient and the family. I know it is beyond whatever I can do, and I leave it up to the psychiatrist for a diagnosis.

Dr. T: Can you treat him spiritually?

Rev. D: Some of these patients will have real questions about God and religion. I give blessings, Holy Communion, where it is indicated, daily prayers, and frequent visits to patients where indicated.

Dr. T: What about a Mongol if the family wants you to do something.

Rev. D: I would talk to the family, but for the Mongoloid I give him a blessing of the Church, and put him in the hands of God, in God's wisdom to take care of him. I think this is what we all do. I think, in my faith and my training, everything tells me that something is being done. I have seen it many times with this expectation that something can be done. That element of hope and optimistic expectation is very important both to the clergyman and to the patient.

Rev. A: I would hope that the clergyman would go in the expectation that in some way God was there and was acting in some good way, even though the clergyman could not determine it. This is an act of faith.

Rev. D: The most frustrating type of patient to me is the alcoholic. I can go more blindly in faith with a Mongol than when I have to deal with alcoholics. I am too much involved with them. I do not believe that anything can be done. They just want to take your time and possess you. I want to do them a bit of good. As a clergyman and according to my own integrity, if I didn't have faith in God and the Church and the sacraments, I would give up. If I could be selective of patients I see, they would be out. These are to me the most frustrating, because I, as a man, don't see what I am doing for them, and I am in a long line of men who are being used.

Rev. G: That is the way I feel with a hypochondriac.

Rev. E: Do the doctors get the feeling that the clergy will go to the doctor and ask the real truth regarding the life of the patient, and all doors are closed except insofar as the medical judgment is concerned?

Dr. I: I have not had that kind of an experience. I don't always tell my minister friends everything about the patient's medical history, simply because I am not sure they are asking entirely for reasons of help. I have the same feeling about ministers as I do about physicians. But if a minister comes to me and wants to know the medical diagnosis in an effort to help, I am delighted to give all I know. But if I think it is curiosity, I will give him the same information he would get through the Admitting Office.

Rev. A: When the doctor says that the patient has a particular kind of cancer, this gives me some kind of knowledge and expectation, and whatever I do from then on is predicated solely by what the doctor has told me.

Aids in Facing Death: Prayer, Preparation, Love

Rev. A: Everybody has to talk out of his experience. I am in a large parish, and we have a great deal of sickness. I know now eight people who have cancer in one form or another to whom I am very close. If I go to a doctor and he says that, in his judgment, the patient not only has cancer, but it will take the man's life within six months or a year, this to me is undoubtedly quite sound as far as the medical side is concerned. Then I ask myself, "What can we bring to bear, if anything, to this situation?" assuming that the doctor is a real Christian and I am a real Christian. Sometimes I think that something else should be added. For three years there has been a prayer group of about ten women. They have met in season and out of season. They took on the blind commitment that in some real way Christ came to heal the sick. The Lord humbled me when I really saw a little group of people who made a faith commitment that the Lord can do something in this world. When I go to visit the sick, I do something more than murmur the words from the Prayer Book. I had done this before, but without the real expectation that Christ would do anything, not really committed myself to say that Christ can and will do something. When I see people now, I believe I am able to pray a much deeper and more honest prayer in the name of Christ than I

did before, because of this small group of Christians who have gone out on this limb. When I talk to people I say, "I know you have this trouble, but I know a group of people who believe that Christ can take a hand in the lives of people. If you will come in and sit in on a meeting, I believe that you will come out of it with the real conviction that Christ is in the middle of the experience. In this sense I believe that Christ can really speak to you and you will know what it is to be healed." If we do believe in God, He has promised to come and to take a hand in the very serious and crucial periods that people go through.

Dr. G: Christ did not promise to spare His followers of suffering, but promised to take away the fear. All of these people are going to die. Christ did not say that physical death has been abolished.

Dr. D: All of life is a preparation for death. We die daily, or we live daily, and I think that this is the emphasis. The time to prepare for death is when people are healthy and not when death is imminent. This is the important time to think about these things.

Rev. A: It is hard to get people when they are well to grapple with this. When I have a patient, sometimes the question is whether or not I really care enough to pay the price, no matter what my schedule is, to get there four times a week. He knows that someone cares, and when this is communicated, you can see the results.

Dr. S: If you want a person to stand on his feet, you must get out of this relationship so that he does not need you four times a week. He must come to it with his own strength.

Dr. D: What the patient wants when he is dying is to feel that God cares, and other people care. I think people can face death better when they have somebody with them who understands that they are going to die.

Dr. K: What bothers me, Rev. A, is that you said these are people that you love. You don't love everybody, and I don't love everybody that I am connected with. I love them inasmuch as they are children of God, but I don't have a personal love for them. That surprised me.

Rev. D: Physicians and clergymen can care about what happens without being lovingly involved.

Dr. S: There are some people who can be awfully hard to care for.

Dr. K: I have a patient who I do not like, but I care about her tremendously.

Dr. D: We are all forgiven sinners, and, therefore, when we get some person who is being sick because she wants to be sick, I think for the Christian the fact that I am like this makes it easier to accept her and try to love her.

Dr. K: My patient is absolutely selfish.

Dr. D: I am the same way, and I need to be forgiven, and it helps to know that we are in the same boat.

Dr. G: The concept of the image of God in every human being is important. The image has been marred, and it may be so much so that I cannot see it, but bear in mind that there is some little remnant.

Rev. D: I mentioned one approach before: to get people to think about death and to talk about it when they are in good health. You almost have to get them in a crisis situation. With all of the deaths with which I have had experience, I take the opportunity to talk to the family about death. This is where I get in the teaching. I have tried in sermons to talk about death. People are not particularly interested when they are in good health. In a crisis situation, you can do it in a small group. If you can do it with the relatives, it is a job well done. With this case I just had, I talked to the husband right there. When his time comes, I hope that we found something together that will stand him in good stead. At two o'clock one morning, I had four members of a family together, and had the opportunity to talk to them. It was a beautiful death. We were all there with the patient when she died. It was the husband who said, "Let us pray."

Rev. A: A Christian, as an individual, must wind up identifying himself at least with some small pocket of Christians with whom he has had an experience of God working through a group of people, and he can do things that he cannot do going out by himself: a small pocket of Christians who have gone out on a limb.

Dr. S: Preparation for all the other sacraments gives the man the strength to go on from day to day so that he does not fatigue and can face death when it comes and stand on his own feet.

Rev. A: I think we should expect something of one another, but I do not think that we should expect an individual to do what a group does. The Lord called 12. He sent them out only after they had had some real appreciation of what it was to be bound together. When people get sick, I have a notion that if I were really living my faith, I would be able to truly communicate to the sick person, "You come with me and we will go to a certain place, and I really believe that Christ will help us in this situation."

A person cannot do what a group can do if the group is really alive.

Dr. D: One of our problems today is that we do not see God at work as He was seen in the past.

The prophets saw the Spirit coming down. If people get together and pray, I think that real things happen. In a group like this one, the Holy Spirit is at work, and things happen that you might not expect to happen.

Why Keep People Alive?

Dr. D: I see many older people with "chronic brain syndrome". Our practice has always been to keep them alive as long as possible. What is the reason we try to keep people alive from a theological point of view? The only justification, I think, is the hope that he will change his relationship with God.

Rev. C: One of the reasons for our hesitation in telling people they are going to die is that in our culture, there is such a fear of death. We cover it over with everything. My reason for telling a man that he will die would not be to convert him, but to try to teach him the great meaning of death. I think death is the most important part of life. If he can face this as a Christian and take full advantage of what death is, this can be the greatest moment in his life. By not telling a man that he is going to die and having him dread it, and talking about him as though he were not a person, it can terrify him.

Dr. K: Don't people open up to you when they find death is inevitable?

Rev. D: They usually talk to me. If someone has a deadly fear of death, I do not think there will be a radical change in his thinking. If he has no fear, he will make his peace with his Maker and accept the fact. The problem is that so many people have this fear. No matter how much theology you tell them, they die a horrible death.

With a person with any religious experience in his life, I have generally found that something happens to that person as he approaches death which I call the merciful preparation of God for death. I have found a different orientation, preparation, or a change of some sort which I attribute to God's mercy and compassion and guidance by the Holy Spirit. More often I have been able to talk to them about death.

Dr. B: I had one experience where a patient committed suicide after being told. This makes me shy in telling others.

Rev. A: I am bothered about the theory of keeping a person alive for extra time, solely in order that he can develop a better relationship with the Almighty. I have a feeling that when Christ came into the world His compassion was the real quality of healing. Compassion itself is more important than hoping the patient will develop a better relationship with God.

Dr. K: Should the physician allow patients to die? We have heard of men who will allow people to die. Do you think they are using compassion? I do not think that they are cutting people off from a relationship with God.

Dr. B: I know a patient, who was a vegetable, who lay for two and a half years in a coma, but one day he awoke. He regained all his faculties. This man was fully conscious of what went on during that time even though he could not tell us. When you get a case like this, who can decide?

Dr. K: There is a child in the hospital now who was supposed to be hopelessly ill, but is now getting more and more normal all the time.

Dr. B: I am bothered by the philosophy of the physician who will let a patient die.

Dr. K: I think you assume a certain amount of responsibility with your education, teaching, and experience. To some physicians, there is a justification which they use in letting a person die. I would want somebody to let me die.

Dr. B: Just because you want to die does not make it right. As long as the flesh responds to my ministrations, I must keep on.

Dr. G: There is a theory presented that one of the skills of a physician may be to end life.

Dr. K: There is no question in my mind and none in Dr. B's that we are right, and yet we are on opposite sides. One has to take one's responsibility. I have just seen an aunt die whose physician was exquisitely sensitive.

Dr. G: I do not think you can have a hard and fast rule. You have to differentiate between the doctor who is motivated by humanitarianism and one who looks upon his profession as the agent of the Almighty, in which case there is one patient in whom he may allow life to terminate and another where he persists. There are people who have been allowed to die because the physician felt that he was doing the will of God.

Dr. K: Would you modify your stand on this, Dr. B?

Dr. B: Yes, I am sure if I had a terminal cancer patient, I would not be heroic. If I give them maintenance and they live, however, I am not going to clamp off the intravenous fluids.

Reprints may be obtained from Church of Our Savior, 360 North Broadway, Baltimore, Md. 21205.

your medical faculty at work

by John Sargeant
Executive Secretary

At the Executive Committee meeting held on Thursday, May 8, 1969, the following actions were taken:

1. Determined that Council meetings held before and after House of Delegates sessions should not be marked "closed sessions" in the printed program of the Annual Meeting.
2. Reaffirmed the Faculty's position of support of Senate Bill 512, which would establish a Commission on Optometry Discipline.
3. Decided that the President, President-elect, Council Chairman, and Executive Secretary should represent the Faculty at any conference with the Governor to discuss mutual health problems. Should any of the other officers be unable to attend, the Council Vice-Chairman will act as a substitute.
4. Submitted the following list of individuals to the Governor for consideration for appointment by him to the Commission on Medical Discipline:

   John M. Dennis, MD, Baltimore
   George R. Spence, MD, Silver Spring
   Charles Bagley, III, MD, Salisbury
   Charles R. MacDonald, MD, Glen Burnie
   Charles F. O'Donnell, MD, Towson
   Karl F. Green, MD, Westminster

   All of these names were submitted by the component societies of the Faculty, in accordance with the law.
5. Agreed to meet with the Executive Committee of the Maryland State Dental Association to discuss mutual problems.
6. Designated John C. Krantz to serve as the Faculty's designee to attend the 1970 Decennial Pharmacopoeial Convention.
7. Heard various items, including information that the Nurses Liaison Subcommittee has given an opinion that licensed practical nurses may administer intradermal injections for tuberculosis, but that this should not be delegated to unlicensed persons.
8. Heard that the case of Joseph Fazekas, MD, against the Suburban Hospital Association had been settled, and the Faculty can consider its participation in this matter closed.
9. Authorized expenditure of funds to combine various Faculty publications into one publication for distribution to members and newly-licensed physicians.
10. Agreed to withdraw as a member of the Administrative Committee of the Regional Medical Program, since no further benefits can be gained by continuing membership in this group.
11. Approved new proposed nursing home regulations to be published by the State Health Department.
12. Authorized submission of two names to be considered for appointment to the Continuing Committee to Study the Medical and Surgical Fees Under Workmen's Compensation Commission.
13. Authorized sustaining membership in the Maryland Public Health Association.
14. Authorized revision of the list submitted to the Governor for appointments to the Board of Physical Therapy Examiners.
15. Declined to provide lists of expert witnesses to testify in court cases concerning criminal charges against a physician, such action being taken on the advice of legal counsel.
16. Authorized free use of Olser Hall by the staff of the Division of Alcoholism Control, State Department of Mental Hygiene.
17. Authorized formation of an Ad Hoc Committee on Dialysis Standards.
18. Submitted to the AMA Council on Medical Education a list of Directors of Medical Education and others to be invited to a regional meeting in New York city on July 12, 1969.

Skilled Hands That Care



Twenty four hours a day . . . in bright, modern facilities, the aged, chronically ill and convalescent, receive professional care, nutritional balanced foods . . . and occupational and recreational therapy programs.

Competent registered nurses see that your instructions are followed exactly.

HOUSE IN THE PINES
NURSING HOMES

Baltimore, Md.
BEL-AIRE—5837 Belair Road.....CL 4-8800
BELVEDERE—2525 W. Belvedere Ave.....FO 7-9100

Catonsville, Md.
CATONSVILLE—16 Fusting Ave.....RI 7-1800

Easton, Md.
EASTON—Rt. 50 & Dutchman's Lane.....TA 2-4000
Your Inspection Invited—Brochure Upon Request

SKIN PROBLEMS

Caused by itching due to:

Dry Eczema	Acne
Chafing	Ivy Poisoning
Minor Burns	Cold Sores
Athlete's Foot	Heat Rash
Dry Skin	Diaper Rash
Wind Burn	Chapping
Insect Stings	Hemorrhoids

?

For Safe, Sure, Speedy Relief —
— Get RESINOL GREASELESS!

Medical Scientists have conquered 6 dread diseases in the past decade, but they are largely in the dark, they admit, in finding relief for one age-old ailment—itching

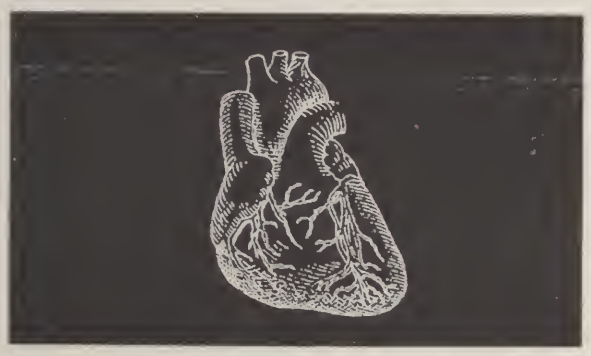


New remedies containing antibiotics have been tested, but have often caused side effects which are worse than itching skin. After many years of research and testing, Resinol Greaseless Cream was developed. . . . A doctor's formula containing safe yet powerful ingredients, Resinol Greaseless contains an amazing, proven "anti-itch" medication called Resorcin, which quickly and effectively relieves most any kind of itching. Try Resinol Greaseless . . . You'll be delighted to find that it really works! At all drug stores. Buy a tube today.

Family First Aid
in a Tube
Carry in Purse
or Pocket
A Medicine Cabinet
"Must"

"Resinol Really Works"

RESINOL CHEMICAL COMPANY
517 W. Lombard St.
Baltimore, Md. 21201



JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Artificial Cardiac Pacing—Current Status

MIRIAM L. COHEN, MD
RICHARD D. BIGGS, JR., MD
Senior Fellows-in-Cardiology
University of Maryland School of Medicine

The earliest recorded instance of successful electrical stimulation of the heart was in 1870 when Duchenne used this technique on the pericardium of a patient dying with bradycardia. Few advances were made until 1952, when Zoll reported use of externally applied electrodes to pace the heart of patients with Adams-Stokes disease. In the late 1950's internal cardiac pacing, utilizing endocardial catheters and epicardial electrodes, was reported.

The types of pacemaker units now available can be categorized in various ways. Temporary pacing for transient rhythm disturbances requires an external power source (impulse generator) which is connected to a transvenously-placed electrode catheter, the tip of which is in contact with the right ventricular endocardium. Permanent pacing may be established in either of two ways: (1) electrodes may be sutured to the epicardium via a thoracotomy, or (2) an electrode catheter may be inserted through a peripheral vein and advanced into the apex of the right ventricle. Each of these systems has as its energy source a subcutaneously-placed impulse generator. These implantable battery units are basically of two designs. One functions to stimulate the heart at a fixed, predetermined rate. The other, the demand type, is synchronized to pace only when the patient's intrinsic rate falls below a pre-set level.

Indications

At present, electrical pacing is recommended for individuals with complete and high-grade atrioventricular block and symptomatic bradycardia of any type. Some authorities also advocate electrical pacing for prevention and treatment of recurrent tachyarrhythmias. Lightheadedness, fatigue, weakness, congestive heart failure, syncope, and angina pectoris are often manifestations of these arrhythmias.

Pacemaker Follow-Up

The importance of continuous, long term follow-up of patients with permanent pacemakers is becoming increasingly evident. The average life of the power-source batteries is usually in the range of 15 to 30 months. Battery failure may be first manifest, particularly in a fixed-rate unit, by an alteration of $\pm$ 5 beats per minute. Some centers evaluate pacemaker function by interval electronic analysis of the generator wave form. All methods of follow-up care are directed toward early detection of battery failure, so that complete battery failure and subsequent return of symptoms can be avoided. To this end, it is currently recommended that a patient with a pacemaker be taught to count his own pulse each day and that he be seen at least every three months by his physician. At each return visit, the patient should be evaluated clinically and electrocardiographically. The EKG will indicate significant changes

in heart rate and may provide evidence of failure of the pacemaker impulse to stimulate the heart.

Complications

Though pacemakers are most beneficial and are frequently life saving, they are not without problems. The complications encountered most frequently in several large series are noted in Table 1. In addition, approximately 3% of patients who have had pacemakers inserted may have early or late failure to pace or intermittent pacing because of hypokalemia.

Displacement of the catheter electrode tip often results in failure of pacing and a return to the patient's intrinsic rhythm. Likewise, electrode wire breakage, battery failure, insulation defects, and penetration of the myocardium by the catheter tip may all result in pacing failure. Electrolytic, fibrotic, or myocardial reactive changes about the electrodes, known collectively as exit block, may produce intermittent or complete cessation of pacing. The above complications should be promptly corrected; some will require surgical intervention and others may necessitate medical management (e.g., potassium replacement for hypokalemia and corticosteroids in certain types of exit block).

Battery failure may be heralded by a change in rate of pacemaker activity by ± 5 impulses per minute. It is presently recommended that battery replacement be effected shortly following detection of such a change in rate. This procedure obviates the problems attendant to complete pacer unit failure. Such total generator exhaustion may result in no electrical output or may produce extremely rapid cardiac stimulation—a situation termed runaway pacemaker.

The use of a fixed rate pacemaker may, at times, result in the phenomenon referred to as competition. Competition is in evidence when the patient's own rhythm is re-established and the fixed rate pacemaker "competes" with this intrinsic rhythm for control of ventricular electrical activity. Though often benign and the source of irregular cardiac action, competition may produce lethal arrhythmias by the fortuitous occurrence of a pacemaker impulse in the vulnerable portion of the electrical cycle. If competition occurs, or is anticipated, a demand type generator should be substituted for the fixed rate unit.

Infection and thrombosis are often problems associated with the implantation of foreign objects. Fortunately, in the clinical experience with pacemakers, these complications have been infrequent.

Summary

Electronic pacemakers are of increasing benefit for many patients with recurrent and unmanageable arrhythmias. The history of and indications for pacing are briefly reviewed. Stress is placed on careful and attentive observation of these patients following pacemaker insertion; such follow-up by the private physician or a pacemaker clinic is essential in order to detect battery failure and to properly treat complications.

References will be supplied upon request.

TABLE 1

Complications observed in several large series of patients with implanted artificial pacemakers. Percentages are derived from the series at University of Maryland Hospital and other centers.

Complication	Time of Occurrence	Signs and Symptoms	Incidence
1. Displacement of catheter electrode, occasionally with perforation of the ventricle	Usually early	a) Failure to pace b) May pace diaphragm c) May produce chest pain	5–15%
2. Infection in the pacemaker system	Early	Fever, abscess, and sepsis	1–3%
3. High threshold & exit block	Early	Failure to pace or intermittent pacing	2–14%
4. Thrombosis around catheter with pulmonary embolization	Early	Symptoms of pulmonary embolism	Rare
5. Competition	Early or late	Possible ventricular arrhythmia, ? sudden death	15–25% (in fixed rate units)
6. Penetration of the generator pack through the skin	Late	Dehiscence	0–9%
7. Catheter lead breakage or crack in insulation	Late	Intermittent pacing	3–11%
8. Battery failure	Late	Failure to pace or runaway pacemaker	Variable (occurs in all systems with time)

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Comparative Price List:

Generic* vs Brand Name Drugs

In 1968 William J. Peeples, MD, Commissioner of Health, sent to all physicians letters with lists comparing prices of brand name drugs and products distributed by chemical names. The letters were merely informational.

At that time, many physicians were unaware of the extent of price ranges of drugs produced by different companies. Some variations may be justifiable, but others may be questionable. To a greater degree than is generally known, major manufacturers produce drug products which they market under their own name and sell to repackagers and distributors for sale under generic names, or another company name.

Another reason for Dr. Peeples' letters was that several large, reliable manufacturers had reduced prices of their "brand name product" to a point at which they actually were competitive with generic products of an unknown manufacturer, and sold by either a local or out-of-state distributor. Many physicians may not have been aware that the same chemical products were manufactured by various large companies.

Although some of the inexpensive products are not stocked by all pharmacies, the fact remains that they could be obtained. It is possible that pharmacists lacked the confidence to stock the various drugs which, in recent years, have become available from more than one source. Increased use and availability of drugs from companies other than the original manufacturer probably will be the factor which will influence physicians to order more drugs by their chemical names.

The comparative lists were well received by most physicians, as evidenced by numerous requests for additional copies, and it seems timely to reproduce it here.

All avenues to reduce costs without lowering the quality of care for needy patients must be explored, and the Health Department will continue to distribute information on prices of drug products as it becomes available. The task of reducing drug costs must be a joint effort on the part of prescriber and dispenser. It would seem that good prescription practices are far more efficacious to economy than formularies can ever be.

** The term "generic equivalent" was not used in any recent HEW Drug Task Force reports because many differing interpretations have caused confusion; for the same reason, it is not used here.*

MARYLAND MEDICAL ASSISTANCE PROGRAM
TRADE NAMED DRUGS AND RESPECTIVE GENERIC COUNTERPARTS

BRAND NAME		*Whlse. Cost **	*COMPARABLE GENERIC*		*Sample Whlse. Cost **
Analgesics					
1) Bufferin 5 Gr	100	1.09	Buffered Aspirin 5 Gr	100	.35
2) Empirin Compound Tablets	100	.90	A.P.C.	100	.30
3) Tylenol 5 Gr	100	1.90	Acetaminophen	100	.60
Anemia					
1) Feosol Tablets 5 Gr	100	1.00	Ferrous Sulfate 5 Gr	100	.30
2) Feosol Spansules	30	1.23	Ferrous Sulfate Time Release	100	1.25
3) Fergon Tablets	100	.80	Ferrous Gluconate 5 Gr	100	.45
Anti-Allergics					
1) Chlortrimeton Tablets 4 Mg	100	2.43	Chloropheniramine Maleate Tablets 4 Mg	100	.40
2) Benadryl Elixir	16 oz	1.59	Diphenhydramine Elixir	16 oz	.75
Anti-Infectives					
1) Achromycin 250 Mg	100	11.22	Tetracycline HCI 250 Mg	100	2.50
Panmycin HCI Mg	100	14.94	Tetracycline HCI 250 Mg	100	2.50
Sumycin 250 Mg	100	4.25	Tetracycline HCI 250 Mg	100	2.50
Tetracyn 250 Mg	100	4.25	Tetracycline HCI 250 Mg	100	2.50
2) Terramycin 250 Mg	100	17.80	Oxytetracycline 250 Mg	100	3.00
3) Pentids 200 Mu	100	5.25	Penicillin G, Potassium 200 Mu	100	1.20
Pentids 400 Mu	100	8.45	Penicillin G, Potassium 400 Mu	100	2.25
4) Gantrisin .5 Gm	100	2.94	Sulfisoxazole .5 Gm	100	1.60
5) Azo-Gantrisin	100	4.13	Azo-Sulfisoxazole	100	2.80
Arthritis and Allied Disorders					
1) Meticorten 5 Mg	100	10.80	Prednisone 5 Mg	100	.90
Deltasone 5 Mg	100	2.25	Prednisone 5 Mg	100	.90
Cardiovascular Disease and Hypertension					
1) Peritrate 10 Mg	100	2.50	Pentaerythritol Tetranitrate 10 Mg	100	.45
Peritrate 20 Mg	100	3.75	Pentaerythritol Tetranitrate 20 Mg	100	.50
Peritrate 10 Mg with Pb	100	2.75	Pentaerythritol Tetranitrate 10 Mg with Pb	100	.55
Peritrate 20 Mg with Pb	100	4.25	Pentaerythritol Tetranitrate 20 Mg with Pb	100	.60
2) Raudixin 50 Mg	100	3.00	Rauwolfia Serpentina 50 Mg	100	.40
Raudixin 100 Mg	100	5.00	Rauwolfia Serpentina 100 Mg	100	.50
3) Serpasil .25 Mg	100	4.50	Reserpine .25 Mg	100	.35
Gastro-Intestinal					
1) Maalox Suspension	12 oz	1.18	Magnesium Aluminum Hydroxide Gel	16 oz	.50
2) Amphojel Suspension	12 oz	1.02	Aluminum Hydroxide Gel	16 oz	.56
3) Gelusil Liquid	12 oz	1.10	Aluminum Hydroxide Gel with Mag. Trisilicate	16 oz	.75
4) Milk of Magnesia, Phillips	12 oz	.60	Milk of Magnesia, U.S.P.	16 oz	.36
Genito-Urinary					
1) Mandelamine 500 Mg	100	3.50	Methenamine Mandelate 500 Mg	100	1.20
Mandelamine 1 Gm	100	5.60	Methenamine Mandelate 1 Gm	100	1.75

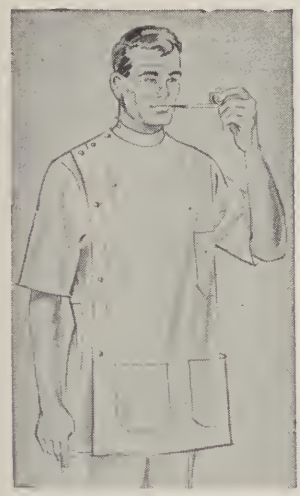
** Allowance should be made for slight variations from the prices listed herein. Prices shown have been updated as of March 1, 1969.*

BRAND NAME		Whlse. Cost *	COMPARABLE GENERIC		Sample Whlse. Cost *
Hypnotics and Sedatives					
1) Noctec Capsules 500 Mg	100	4.20	Chloral Hydrate 500 Mg	100	1.45
2) Nembutal Sodium Capsules 1½ Gr	100	2.16	Pentobarbital Sodium 1½ Gr	100	.90
3) Seconal Sodium Capsules 1½ Gr	100	2.16	Secobarbital Sodium 1½ Gr	100	.95
4) Butisol Sodium Tablets ¼ Gr	100	1.55	Butabarbital Sodium Tablets ¼ Gr	100	.35
Butisol Sodium Tablets ½ Gr	100	2.05	Butabarbital Sodium Tablets ½ Gr	100	.45
Butisol Sodium Elixir	16 oz	2.90	Butabarbital Sodium Elixir	16 oz	1.15
Neuropsychiatric					
1) Miltown, Equanil 200 Mg	100	5.20	Meprobamate Tablets 200 Mg	100	2.05
Miltown, Equanil 400 Mg	100	6.50	Meprobamate Tablets 400 Mg	100	2.80
Stool Softeners					
1) Colace Capsules 100 Mg	60	3.77	Dioctyl Sodium Sulfosuccinate Capsules 100 Mg	100	.90

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#800—100% Nylon Taffeta **$5.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only

Sizes 34 to 46



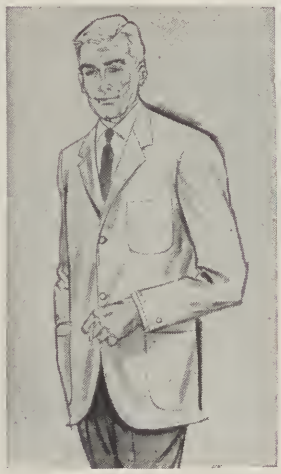
- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46



MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

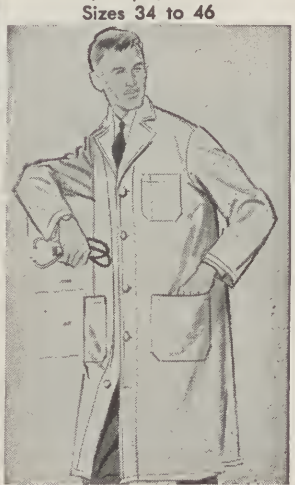
Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab. **$9.99**

Sizes 28-40



OTHER STORES IN →

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639

RUN RIGHT TO Read's DRUG STORES

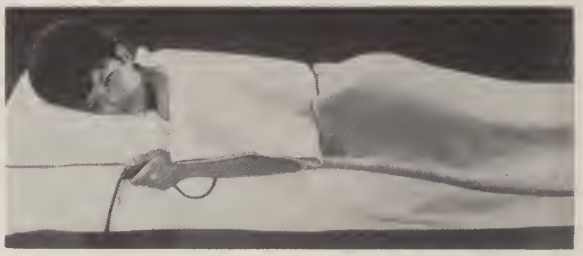
TWO ALL NIGHT DRUG STORES

★ INGLESIDE SHOPPING CENTER
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ HILLENDALE SHOPPING CENTER
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

Now When You Recommend Moist Heat,



Recommend Automatic Moist Heat.

Until now, application of moist heat required boiling water, hot towels, and somebody to apply them. The Battle Creek THERMOPHORE changes all that. It provides instant and automatic moist heat, intensely hot, deeply penetrating. The patient simply plugs it into an outlet. This unique hot fomentation pad then generates its own moisture from the air. Intensely hot moist heat is constantly maintained, and evenly distributed throughout the pad. No water is needed, no filling or emptying is required.
Large 13" x 27" pad covers back, or chest and abdomen, or both legs. Safety thermostat turns it off automatically, prevents overheating.
Price is **$35.00.** Also available in medium size 13 x 13 **$25.00.**
Phone for Free Descriptive Literature, or See It At . .

THERAPEUTIC APPLIANCES, INC.
JULES MORSTEIN
1114 Light St. **Phone 752-6996**
Baltimore, Md. 21230

★ This extended care Nursing Home is Approved by the Joint Commission on Accreditation of Hospitals
★ One story new fire-safe construction.
★ No steps, ramps or elevators needed.
★ Inspection invited. Reasonable rates.
★ All facilities available to private physicians.

Where your convalescent Elderly, Bedfast or Disabled

Enjoy being special

V. I. P.'s

(VERY IMPORTANT PARENTS)



★ Professional Total Care Program
★ Continuous Physical Rehabilitation by registered therapists in specially equipped department.

PHONE VALLEY 8-6500

Dulaney Towson
NURSING & CONVALESCENT HOME
111 West Road, Towson
Off York Rd. Beltway Exit 26 South



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

On Baltimore's Mental Health Problems and Needs

The continuing increase observed for some time in the number of admissions to Maryland's mental hospitals has been primarily related to the growing need for inpatient treatment by Baltimore city residents. While admission rates have traditionally been higher in the city than in other areas of the state, this gap has widened appreciably in recent years. If presently existing conditions remain unchanged, it must be anticipated that this disparity will increase at an accelerating pace.

ADMISSION RATE *

Fiscal Year	Baltimore City	Maryland Excl. of Baltimore	Four Suburban Counties	Nine Eastern Shore Counties	Ten Other Counties
1963	377.7	150.0	137.3	275.3	139.2
1964	415.3	159.2	143.1	267.7	161.5
1965	457.0	167.1	150.8	295.0	156.8
1966	516.9	177.4	166.7	306.8	186.6
1967	643.1	179.5	171.4	297.9	169.9
1968	714.3	182.8	173.8	294.6	165.4

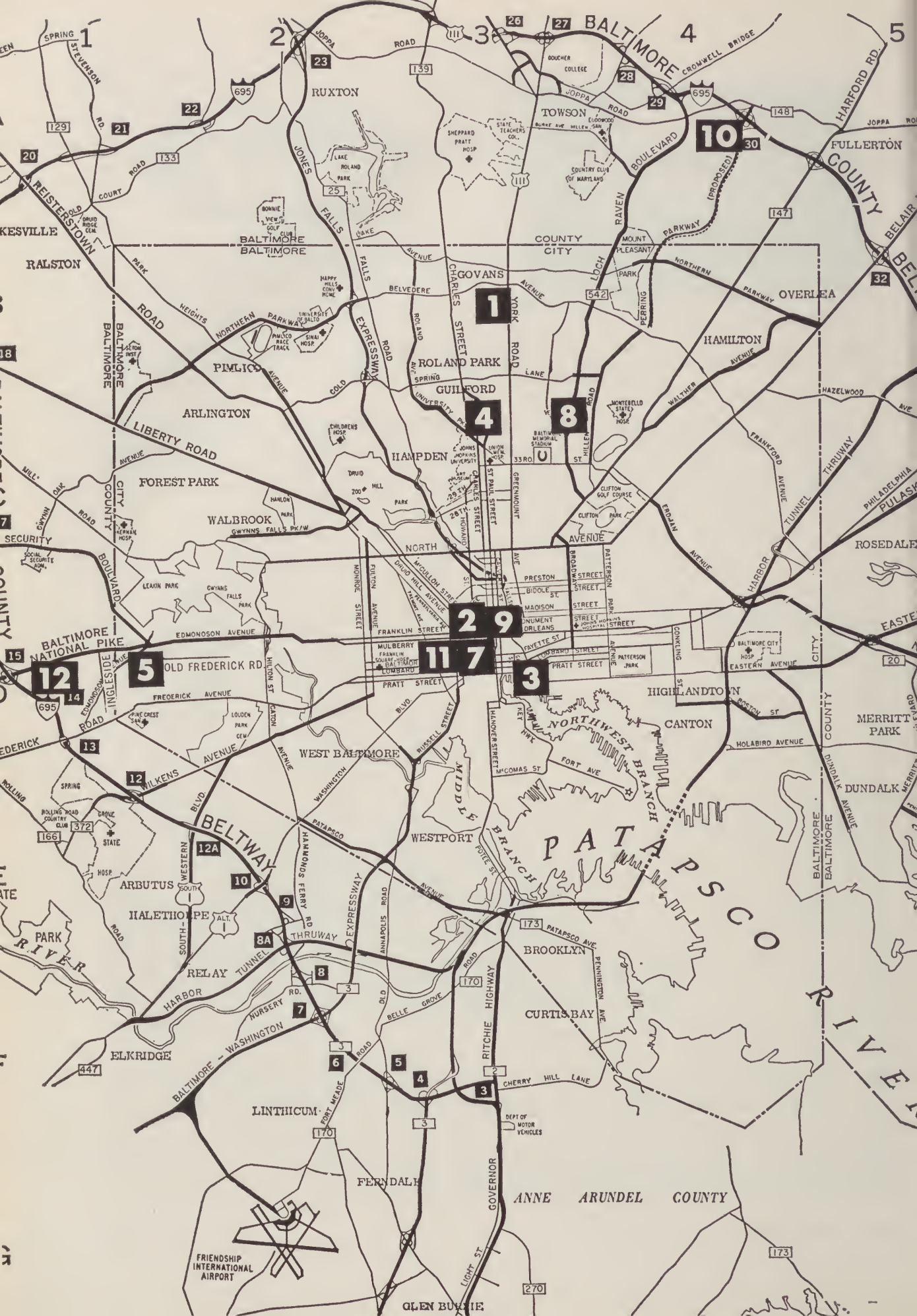
** Number of admissions per 100,000 estimated population in specified area and year.*

Baltimore's population, as in most urban centers, is virtually stationary in size and accounts for a declining proportion of total state residents. While 28.8% of Maryland's population lived in the city at the beginning of 1963, this decreased to 23.0% by 1968. Despite this, 48.5% of the 7,257 state hospital admissions in 1963 and 54.1% of the 11,997 admissions in 1968 lived within the city confines. A similar upward trend has been noted in psychiatric outpatient units. These data reflect a general pattern of expanding health problems in Baltimore resulting from the white middle-class mass exodus to suburban counties and their replacement in many cases by poor, culturally deprived and community dependent residents.

An earlier report,[1] based on data from the Maryland Psychiatric Case Register, showed that major variations existed also within Baltimore. This study reported that the proportion of the total population admitted to inpatient care (in all public and private facilities) during a three year period (1961-1964) ranged from 0.42% in an outlying area to 8.16% in an inner city tract. Rates for middle class sections in most cases did not differ appreciably from comparable figures for similar areas beyond the city limits. Differences in admission rates between Baltimore and surrounding counties were almost entirely accounted for by the very high rates in inner city slum tracts.

Endeavors to reverse presently existing trends should receive the active support of all state residents since Baltimore and the rest of Maryland are vitally inter-dependent. These efforts require the development and expansion of community-centered mental health services in close coordination with other agencies and programs seeking to overcome the causes and effects of cultural, economic, and social deprivation.

[1] *Klee, Gerald D.; Bahn, Anita K.; Spiro, Evelyn, and Gorwitz, Kurt; "An Ecological Analysis Of Diagnosed Mental Illness in Baltimore." Published in Psychiatric Research Report 22 of the American Psychiatric Association.*


1
2
3
4
5
BALTIMORE
RUXTON
TOWSON
FULLERTON
COUNTY
BALTIMORE COUNTY
RALSTON
REISTERSTOWN
PIMLICO
ARLINGTON
LIBERTY ROAD
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
OVERLEA
HAMILTON
FOREST PARK
WALBROOK
NORTH
PRESTON STREET
BIDDLE ST.
MADISON STREET
FRANKLIN STREET
MULBERRY
PRATT STREET
EDMONDSON AVENUE
BALTIMORE NATIONAL PIKE
OLD FREDERICK RD
FREDERICK AVENUE
WEST BALTIMORE
HIGHLANDTOWN
CANTON
NORTHWEST BRANCH
MIDDLE BRANCH
PATAPSCO RIVER
DUNDALK
MERRITT PARK
BELTWAY
WESTPORT
ARBUTUS
HALETHORPE
PARK
RELAY
BROOKLYN
CURTIS BAY
ELKRIDGE
LINTHICUM
FERNDALE
ANNE ARUNDEL COUNTY
FRIENDSHIP INTERNATIONAL AIRPORT
GLEN BURNIE
SECURITY
ROSEDALE
HARFORD RD.
JOPPA ROAD
CROMWELL BRIDGE
LOCH RAVEN BOULEVARD
CHARLES STREET
YORK ROAD
FALLS ROAD
JONES FALLS EXPRESSWAY
NORTHERN PARKWAY
BELVEDERE AVENUE
HILLEN ST.
GREENMOUNT AVE
HOWARD STREET
PATTERSON PARK AVENUE
EASTERN AVENUE
HOLABIRD AVENUE
DUNDALK AVENUE
PATAPSCO AVE.
PENNINGTON AVE.
RITCHIE HIGHWAY
CHERRY HILL LANE
BALTIMORE - WASHINGTON BLVD
ANNAPOLIS ROAD
HANOVER STREET
RUSSELL STREET
MONROE STREET
FULTON AVENUE
HILTON ST.
CATON AVENUE
WASHINGTON BLVD
HAMMONDS FERRY RD
SOUTH-WESTERN
THRUWAY
HARBOR TUNNEL
FRANKFORD AVENUE
PHILADELPHIA
PULASKI
BALTIMORE CITY HOSP.
JOHNS HOPKINS UNIVERSITY
UNIVERSITY OF BALTO.
SINAI HOSP.
SHEPPARD PRATT HOSP.
STATE TEACHERS COL.
COUNTRY CLUB OF MARYLAND
MONTEBELLO STATE HOSP.
CLIFTON GOLF COURSE
BALTIMORE MEMORIAL STADIUM
DEPT OF MOTOR VEHICLES
GOVERNOR
LIGHT ST.
PORTE ST.
McCOMAS ST.
FORT AVE.
BOUCHER COLLEGE
LAKE ROLAND PARK
CLIFTON PARK
PATTERSON PARK
LEAKIN PARK
GWYNNS FALLS PARK
LOUDEN PARK CEM.
PINE CREST SAN.
KERNAN HOSP.
SOCIAL SECURITY ADM.
POLING ROAD COUNTRY CLUB
STATE HOSP.
BONNIE VIEW G.C.
DRUID RIDGE CEM.
HAPPY HILLS CONV. HOME
PIMLICO RACE TRACK
CHILDREN'S HOSP.
ST. PAUL STREET
CHARLES STREET
20TH
25TH
29TH
33RD
200 HILL
DRUID PARK
MOUNT PLEASANT PARK
PERRING PARKWAY
WALTHER AVENUE
HAZELWOOD AVE.
ERDMAN AVENUE
GWYNN OAK AVENUE
COLD SPRING LANE
UNIVERSITY PKWY
ROLAND AVE.
FALLS ROAD
PARK HEIGHTS AVENUE
OLD COURT ROAD
DRUID HILL AVENUE
McCULLOH STREET
CONKLING ST.
PRATT STREET
LOMBARD STREET
FAYETTE ST.
MONUMENT STREET
ORLEANS STREET
JOHNS HOPKINS HOSPITAL
BALTIMORE CITY HOSP.
EASTERN AVENUE
PATTERSON PARK
ROSTON ST.
HANOVER STREET
MIDDLE BRANCH
NORTHWEST BRANCH
PATAPSCO
BELLE GROVE ROAD
OLD FORT MEADE ROAD
NURSERY RD.
SOUTH-WESTERN
ALT. 1
SOUTH
BALTIMORE
COUNTY
CITY
BELAIR
PARK
RIVER
ROAD
AVENUE
BOULEVARD
PARKWAY
TUNNEL
THRUWAY
EXPRESSWAY
HIGHWAY
LANE
ST.
STREET
PROPOSED
695
129
133
139
147
148
542
372
166
447
173
270
10
30
32
18
15
14
13
12
12A
9
8A
8
7
6
5
4
3
2
20
22
23
26
27
28
29

Restaurants of Distinction

Locations indicated by numbers on map

6

MILTON INN

Circa 1740

Dine Amid Early American Charm
Warm, Gracious and Inviting

Selected By Life & Time Magazines as One of America's Finest Inns

Lounge & Dining Room Available for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.

SPARKS 771-4366

11

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*



Your Host
Tom d'Anna

539-9021

12

Dobbs House

Breakfast-Luncheon-Dinner
Banquets-Meeting-Private Parties
We Cater Wedding Receptions

Located in Quality Court Motel—West U.S. Route 40 & Beltway Exit 15

5801 Baltimore National Pike

744-1510

5



Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS

Finest Sea Foods
Prime Meats

5653 Old Frederick Road

East of Ingleside Ave., off Baltimore National Pike

TED KUCHTA, *Manager*

Phone 744-0223

10



SPECIAL AT THE

FABULOUS CLUB VENUS

An Evening for Two . . Only $15

Offer good every night except Saturday
Make Reservations Now

Perring Plaza Shopping Center—Beltway Exit 30

***For Reservations Call* NO 8-2232**

7

Miller Bros.

"The Place to Eat"



NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call **752-4822**

3

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

Baltimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center
Open 12 noon to 3 A.M.—Closed Mondays

For Reservations Call 685-2811

2 blocks south of the Flag House

300 ALBEMARLE STREET

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

4

Broadview Restaurant

Cocktails • Dinners • Luncheons

Private Entertaining Facilities

116 W. University Parkway at 39th St.
CALL CH 3-1216

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD

Cocktails **Mexican Beers**

Tuesday thru Sunday

Open 5:00 P.M.---12:00 P.M.

Dinner and Snacks

Closed Monday

Phone 435-9858

9

Cork 'n Bottle Restaurant

STEAK — SEAFOOD — PRIME RIB

COCKTAILS

LUNCHEON — DINNER

Major Credit Cards Honored

Private Party Rooms

22 E. FAYETTE ST. BALTIMORE, MD.

½ Block from Charles Center

539-1268

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE

Baltimore 1, Md. **MU 5-6790**

CARRY-OUT SERVICE

SPECIAL LUNCHEON and DINNERS

PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.

Sunday 12 Noon to 3 A.M.

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

PROFESSIONAL LEASING
Special low rates for our medical customers. Call or stop in.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL
5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

Brentwood Inn

FRENCH CONTINENTAL CUISINE

Smorgasbord Luncheon and Dinner every Tuesday . . . . .

"Home of Maryland's Internationally Famous Wine Cellar" . . . .

We honor all preferred Credit Cards

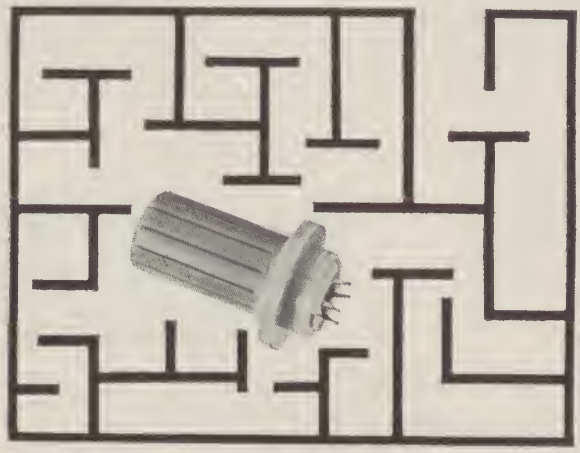
• *NEW!* Another Dining Room has been added to accommodate our many guests •

OPEN DAILY & SUNDAY 11 A.M. to 2 A.M.

Fifth Ave. & Brentwood—1 block N. E. of Dundalk and Holabird Ave. 1 mile from Holabird Ave. Exit of Baltimore Harbor Tunnel

We cater to Private Parties, Banquets and Dinners

AT. 5-0520 *Ample Free Parking* BALTIMORE, MD. 21222



HISTO IS CONFUSING.

Histoplasmosis can mimic such unrelated diseases as TB, leukemia, pneumonia and syphilis. Use the blue Histoplasmin LEDERTINE™ Applicator as the first step in differential diagnosis and as a routine step in physical examinations for the permanent records of your patients.

HISTOPLASMIN, TINE TEST
(Rosenthal)

Precautions—Nonspecific reactions are rare, but may occur. Vesiculation, ulceration or necrosis may occur at test site in highly sensitive persons. The test should be used with caution in patients known to be allergic to acacia, or to thimerosal (or other mercurial compounds).

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York
473-9



CCTV TOTAL SYSTEMS

PLANNING, ENGINEERING, INSTALLATION & SERVICE
We Feature **AMPEX**
VIDEOTAPE RECORDING EQUIPMENT
Call Today for a Free Demonstration

high fidelity house

6307 YORK ROAD BALTIMORE, MD.
(Drumcastle)
Phone 323-3713

In the complex picture of moderate to severe anxiety...



there is a new reason for prescribing Mellaril (Thioridazine HCl)

effectiveness in mixed anxiety-depression

Long recognized for its usefulness in the treatment of moderate to severe anxiety, Mellaril is now also known to be effective against mixed anxiety-depression.

Often the symptoms of anxiety states are difficult to sort out—even with the most careful probing. The patient may manifest symptoms of agitation, restlessness, insomnia, somatic complaints. But what of the depression that may be mixed in the total picture? It is reassuring to know that Mellaril may be prescribed—with strong possibilities of success—when there is anxiety alone or a mixture of anxiety and depression.

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine hydrochloride). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

Mellaril®
(Thioridazine HCl) 25 mg. t.i.d.

for moderate to severe anxiety and mixed anxiety-depression

SANDOZ SANDOZ PHARMACEUTICALS, HANOVER, N. J. 68-169



...now fast relief of hay fever symptoms with

NTZ®

Nasal Spray

When pollens fly, just one or two squirts of NTz in each nostril, followed in a few minutes by a second spraying, shrink swollen nasal passages almost on contact. And breathing comfort follows. The antihistamine component of NTz helps combat the allergic reaction and lessen rhinorrhea, sneezing and itching; its antiseptic wetting agent promotes rapid spread of components.

NTz Nasal Spray affords the well-known benefits of Neo-Synephrine® in a carefully balanced formula which includes:



Winthrop

Neo-Synephrine® (brand of phenylephrine) HCl, 0.5% (adult strength), decongestant
Thenfadil® (brand of thenyldiamine) HCl, 0.1%, antihistamine
Zephiran® (brand of benzalkonium as chloride, refined) Cl, 1:5000, antiseptic wetting agent

Treatments with NTz should be repeated every three or four hours as needed. NTz is for temporary relief of nasal symptoms and overdosage should be avoided. Available in squeeze bottles of 20 ml. and 1 oz. bottles with dropper.

Winthrop Laboratories, New York, N.Y. 10016 (1289)

When it's more than a bad cold



your patient can feel better while she's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

327-8

now she can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

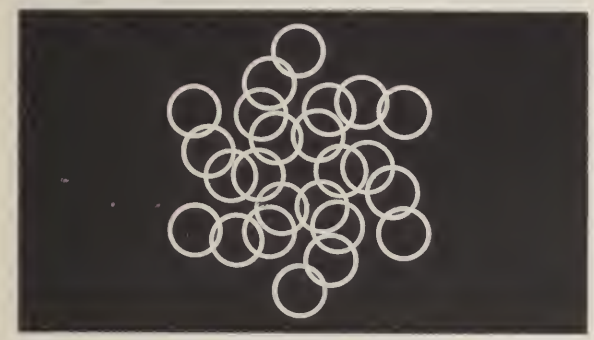
Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.





From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

The Alcoholic in the Emergency Room

Alcoholics are being examined and treated at an increasing rate in hospital emergency rooms throughout the state. Under Maryland law, the medical services of the general hospital are expected to care for the needs of the intoxicated patient, without discrimination, in accordance with the accepted standards applying to other presenting patients. However, because of the stigma associated with alcoholism and because of the lack of training of medical students and nurses in this disease, the alcoholic is often treated improperly.

This paper discusses the important principles of emergency treatment of alcoholics. The many medical and surgical complications are beyond its scope, so that only acute intoxication and acute withdrawal syndromes will be considered. The paper concludes, however, with a discussion of the nature of the follow-up which is so necessary to prevent the "revolving door."

RICHARD H. ANDERSON, MD
Assistant Resident in Department of Medicine
University of Maryland Hospital

MAXWELL N. WEISMAN, MD, Director
Division of Alcoholism Control
Maryland State Department of Mental Hygiene

Acute alcohol intoxication, when mild to moderate, usually requires no treatment for recovery other than time to "sleep it off" and to suffer through the hangover. If the intoxicated patient has a home to go to, a family to care for him, and if his intoxication is uncomplicated and of recent onset, he should be sent home without medical treatment. However, the homeless alcoholic who presents to the emergency room without complications is rare, and further evaluation, in his case, is usually indicated. Often, the withdrawal syndrome has begun, or will begin, while he is in the emergency room and then he should be treated accordingly.

Certain individuals who consume relatively small amounts of alcohol will become aggressive, destructive, and severely agitated, but they are rare. This condition, usually referred to as pathological intoxication, may be due to underlying emotional disturbance. The patient should be restrained, if necessary, and carefully sedated to prevent him from harming himself and others. Once the alcohol is eliminated, the patient's behavior will usually return to normal, at which time he should be urged to seek psychiatric treatment and abstain from alcohol.

Stupor from alcohol is common and requires only observation and careful differentiation from the many other causes of stupor. Sedation or use of tranquilizers should be avoided because of possible potentiation of alcohol and precipitation of coma. The blood-alcohol level may be helpful in this regard, but should not be relied upon entirely to differentiate alcohol stupor from other conditions because of the frequent occurrence of concomitant head trauma and infection in the alcoholic.

Alcohol coma is quite rare, but is an emergency because of the possibility of respiratory depression and death. The condition is completely reversible if the patient is supported correctly until the blood alcohol level decreases. It is important to rule out other causes of coma as soon as possible through a history (from friends or family), and physical and laboratory studies with particular emphasis on blood sugar, alcohol and barbiturate levels. An endotracheal tube should be inserted and respiration assisted

if there is any respiratory embarrassment. Gastric lavage may be helpful, but not until after an endotracheal tube is inserted because of the possibility of aspiration. A variety of drugs such as, glucose, insulin, and stimulants have been used, but without particular value and we feel they are not indicated. Some clinicians, however, recommend a 50 cc amp. of 50% glucose IV without waiting for results of blood studies in order to prevent possible brain damage in the event of hypoglycemic coma (see below). Hemodialysis may be useful, but its value has not yet been established.

The *withdrawal syndromes* are easily recognized, but their severity is often underestimated and treated incorrectly. The severity of withdrawal is dependent on several factors: the duration of intake, the amount of alcohol ingested, the abruptness of cessation, and individual susceptibility. The cause of the withdrawal syndrome is not clear, but is felt by most investigators to truly represent withdrawal from alcohol. The condition may develop while the alcoholic is drinking if the blood-alcohol level is decreasing, as in "tapering-off," or it may occur several days after complete cessation of alcohol intake.

Alcohol withdrawal may be separated into several syndromes which simply reflect degrees of severity:

The *tremulous stage* is the mildest form of withdrawal. The most common signs and symptoms are tremors, insomnia, anorexia, anxiety, depression, nausea, vomiting, flushed facies, injected conjunctiva, tachycardia and agitation. This state often will subside in several days with abstinence, with another drink, or with mild sedation, or it may progress to delirium tremens.

The *acute hallucinosis stage* usually includes the signs and symptoms of the tremulous stage; but, in addition, hallucinations are present: visual, auditory, or tactile. Characteristically, the hallucinations are threatening and unpleasant, but occasionally may be pleasant. Usually, they are transitory, as is the tremulous stage, but occasionally may last for several months. Chronic hallucinosis in the alcoholic is thought, by many, to represent schizophrenia, but the, frequently, very late age at onset makes this assumption doubtful.

Delirium tremens is a medical emergency requiring immediate hospitalization and treatment. The mortality rate ranges from 5% to 30% with death resulting from peripheral vascular collapse, hyperthermia, and associated infection or head trauma.[1-3] Delirium tremens should not be diagnosed, unless there is evidence of the tremulous state, hallucinations, disorientation at least intermittently, and delirium. The autonomic activity is extreme, with frequent fever, profuse perspiration, tachycardia, tachypnea, and severe agitation. Convulsions ("rum fits") are not uncommon in patients with no previous history of convulsive disorder. Why convulsions occur during alcohol withdrawal is unknown, but they may represent a predisposition to epilepsy which is made manifest by the alcohol withdrawal.

The diagnosis of the withdrawal state is usually made without difficulty, and laboratory studies are of little value in confirming a clinical impression. However, it should be remembered that alcoholics frequently develop medical and surgical conditions, directly and indirectly related to their alcoholism. Consequently, a CBC, urinalysis, blood-sugar, blood-urea-nitrogen, chest X-ray, and skull X-ray are often indicated. In addition, although fever is common in delirium tremens, a careful search for infection should always be made in a febrile alcoholic, and treatment with antibiotics should be initiated immediately after cultures are obtained if an infection is suggested.

Treatment of the withdrawal syndrome is rather controversial, and a review of the medical literature will reveal that a variety of approaches have been used. Virtually every sedative and every tranquilizer has been tried at one time or another. What follows is a suggested regimen which we have found most useful. Each withdrawal stage is treated with the same general measures but, obviously, mild withdrawal requires little treatment, while severe withdrawal requires additional measures.

Sedation is the most important step in treatment and often the most difficult to achieve. A variety of drugs are available and effective, and the physician should use the drug with which he is most familiar. We prefer the minor tranquilizers such as, chlordiazepoxide *(Librium)* and hydroxyzine *(Vistaril)* because of the relatively minor risk of oversedation, addiction, seizure potentiation, and hepatic toxicity. The dosage required to produce sedation (without stupor) varies from 50 to 200 mg IM of chlordiazepoxide or hydroxyzine which may have to be repeated in 2 to 4 hours. Once sedation is achieved, the dose should be reduced to that level which will maintain relative tranquillity (10 to 25 mg q.i.d.) and given per os. Although mild to moderate withdrawal may be treated rather effectively in a few hours to a few days, failure to continue tranquilizers may increase the likelihood of return to alcohol with the patient's attempt to control the symptoms of withdrawal. However, we suggest that only a minimum dose of tranquilizer be supplied to carry the patient over to outpatient services. This is of vital importance, because of the likelihood of dependence upon the tranquilizer and potentiation with alcohol, a particularly dangerous and, possibly, lethal condition for an alcoholic who continues to drink.

Large amounts of fluids given intravenously or orally, and electrolyte replacement have frequently been advocated in treating the withdrawal syndrome,

because of the apparent dehydration of the alcoholic and the known diuretic properties of alcohol. However, investigators have shown recently that there is a rise in total body water with daily ingestion of alcohol, and that alcohol is diuretic, only when the blood-alcohol level is rising.[4, 5] They have shown also that, frequently in the withdrawal period, alcoholics are not dehydrated, but overhydrated. Consequently, in the absence of complications, fluids given intravenously are probably not indicated. In fact, some investigators use diuretics in the treatment of withdrawal. We do not, however, suggest their use at this time since the data attesting their effectiveness are not completely convincing, although their use in the future may be anticipated.

Rarely, however, the alcoholic will present with hypoglycemia either from glycogen depletion in the liver, and malnutrition, or from some direct effect of alcohol not yet clearly understood. Therefore, it is suggested that glucose be given immediately, either orally or intravenously, to the alcoholic in withdrawal period.

It is a well-established fact that a high percentage of chronic alcoholics have a low serum magnesium,[6, 7] and that, with abstinence from alcohol and a normal diet, the magnesium will return to normal in a few days. It has also been shown experimentally that magnesium deficiency will produce many of the signs and symptoms of alcohol withdrawal.[8] Furthermore, the sedative effect of magnesium has been utilized for many years in the treatment of toxemia of pregnancy. For these reasons, many investigators have suggested the use of magnesium sulfate in the treatment of alcoholics.[9-11] Even though there is no conclusive evidence that magnesium alters the course of delirium tremens, we routinely recommend magnesium sulfate 50% solutions 2cc IM q6h for 1 to 2 days.

Others have suggested the routine use of anticonvulsants in the severe withdrawal syndrome to prevent "rum fits.[12] We use anticonvulsants routinely in all patients with a history of seizures, and initiate anticonvulsants in any patients who convulse.

Vitamins are important in the treatment of alcoholism, not because they will alter the course of withdrawal, but because of the multiple vitamin deficiencies so common among alcoholics. The physician has a choice of a large variety of available multiple vitamin preparations. Because of frequent thiamine deficiency, we suggest at least 100 mg of thiamine be given in addition to other vitamins.

Finally, continuous supportive nursing care is essential to alleviate the overwhelming anxiety and fear which is often present. The room should be well-lighted and quiet, and include the presence of a calm member of the family or of Alcoholics Anonymous. Physical restraint should be avoided since this may only increase the patient's fright in rendering him helpless in the face of his monstrous hallucinations, hence more hostile and even combative.

Follow-up. The emergency room is frequently the first, and often the only, point of contact an alcoholic has with medical personnel responsible for the evaluation of his alcoholism or its complications. The Maryland law gives the medical officer of the unit the authority to determine whether the patient should be directly admitted to the hospital for further evaluation and detoxification or other treatment, or referred to another appropriate facility for care and treatment, or denied referral or admission.

The physician in the emergency room is expected to care for the acute medical need, and then to arrange for follow-up when necessary, as in all other chronic illnesses. Whether or not the patient will embark on a long-range program to achieve sobriety and minimize relapses often depends on the positive relationships established in the emergency room.[13] Here, three attributes of the staff, as a whole, are crucial:

1. A non-judgmental attitude characterized by a genuine professional acceptance of the patient as suffering with an addictive illness, and
2. A thorough knowledge of the dynamics of alcoholism as a complex, socio-medical illness so that an objective evaluation can be made of the patient's needs and capacity for recovery, and
3. Knowledge of other agencies involved in follow-up care.

In the medical setting of a hospital where the staff, uniformly, is genuinely convinced that alcoholism is a disease and communicates this concept both verbally and nonverbally, the alcoholic patient may, himself, perhaps for the first time in the history of his illness, emerge from the hopelessness and despair which serve, often, to frustrate the physician's therapeutic regimen. The most degraded alcoholic, if treated consistently with the same dignity which is accorded the victim of any other illness, may find this professional relationship the turning point in overcoming his feelings of rejection and defensive denial of his alcoholic problem. This, however, requires a deep-seated understanding that the alcoholic is not "responsible" for his illness, that he "cannot help" his alcoholism any more than a diabetic is responsible for or can help his diabetes. Neither one, contrary to popular prejudice, is a self-inflicted disease. Both patients, however, can and should be helped to understand the nature of their illness and made responsible for a course of action which can keep them symptom-free, even though neither one may ever be "cured."

Experience in the emergency room indicates that just such a relationship of trust and confidence is closely correlated with the success of further referral to a follow-up program. Such referral will

vary, depending not only on the patient's need, but also on the extent and availability of alcoholism treatment resources within the private or public health sectors of a given community. Where no resources are known and where there is no family physician, the patient should be referred to the local public health officer who is responsible for community programs for treatment, prevention, and control of alcoholism.

While the most effective and most experienced community resource often is the local AA group, together with the associated fellowships of Al-Anon for the spouse and Al-Ateen for the children of the alcoholic, other agencies may also be of help. Visiting nurses, clergymen, staffs of family and social agencies, employers and union counselors, halfway houses, state hospital alcoholic rehabilitation units, vocational agencies, the local council on alcoholism and numerous others, may each have a role to play at various stages of the illness, in helping the alcoholic maintain sobriety. An alcoholism counselor, who may be employed on the emergency room staff, is usually equipped with knowledge of these resources and often the most helpful agent in effecting the referral.

Provided the patient does not object, the law requires that a bona fide attempt be made to notify his immediate family or next of kin. In addition, if for any reason, the patient must receive treatment elsewhere, arrangements for the treatment, together with transportation, must be made. If the patient is without funds, arrangements for transportation to his residence or elsewhere are a hospital responsibility. Further, if he has no residence, an attempt must be made to find and transport him to a facility where he may find shelter. Hospital social service, or the alcoholism counselor, when available, may appropriately be concerned with these alternative arrangements.

Under the law, if the patient is thought by the physician to be unable to make a rational decision concerning his own welfare, he may be admitted and detained involuntarily for treatment purposes until he is no longer intoxicated or incapacitated but, in any event, no longer than 5 days. An additional section of the law allows the patient to be kept for treatment for a period not exceeding 30 days, but it is most unlikely that this provision will be invoked since the patient can, if necessary, be sent to the state mental hospital following detoxification.

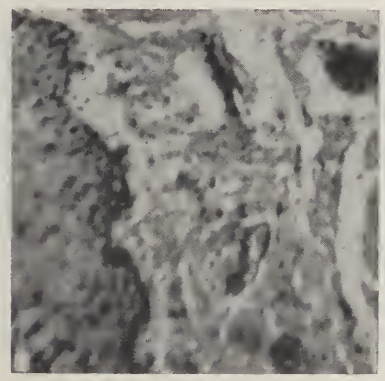
It may be assumed that the alcoholic is seen in the emergency room when he is in serious difficulty and in need of help. The physician who sees him can make a positive contribution to the medical management of this acutely intoxicated individual, but he is not expected to do the total job involved in the care of the alcoholic. All in all, he plays an indispensable role in Maryland's comprehensive program for the prevention, control, and treatment of this complex disease.

REFERENCES

1. Johnson, R. B.: The Alcohol Withdrawal Syndromes, *Quat J Stud Alcohol* **22** (suppl. 1):66, 1961.
2. Figurelli, F. A.; Davis, R.; and Figurelli, J.: Severe and Complicated Delirium Tremens, *Med Times* **90**:1347, 1962.
3. Lundquist, G.: A Comparative Study of Pathogenesis, Course and Prognosis with Delirium Tremens, *Acta Psychiat Scand* **36**:443, 1961.
4. Smith, J. A.: Methods of Treatment of Delirium Tremens, *JAMA* **152**:384, 1953.
5. Beard, J. D.; Barlow, G.; and Overman, R. R.: Body Fluids and Blood Electrolytes in Dogs Subjected to Chronic Ethanol Administration, *J Pharmacol Exp Ther* **148**:348, 1965.
6. Beard, J. D.; and Knott, D. H.: Fluid and Electrolyte Balance During Acute Withdrawal in Chronic Alcoholic Patients, *JAMA* **204**:133, 1968.
7. Flink, E. B., *et al:* Magnesium Deficiency After Prolonged Parental Fluid Administration and After Chronic Alcoholism Complicated by Delirium Tremens, *J Lab and Clin Med* **43**:169, 1954.
8. Mendelson, J. Wexley, *et al:* Serummagnesium in Delirium Tremens and Alcoholic Hallucinosis, *J Nerv Mental Dis* **128**: 352, 1959.
9. Wacker, W. E. C., and Paris, A. F.: Magnesium Metabolism, *New Eng J of Med* **278**:658, 1968.
10. Acton, C.: Detoxification of the Alcoholic Patient, *Dis of the Nerv Syst* **29**:265, 1968.
11. Golbert, T. M., *et al:* Comparative Evaluation of Treatment of Alcohol Withdrawal Syndromes, *JAMA* **201**:113, 1967.
12. Heaton, F. W., *et al:* Hypomagnesaemia in Chronic Alcoholism, *Lancet* **2**:802, 1962.
13. Knott, D. H.; Beard, J. D.; and Wallace, J. A.: Acute Withdrawal From Alcohol, *Postgraduate Medicine*, A-109, 1967.
14. Chafetz, M. E.: Motivation for Recovery in Alcoholism, *Alcoholism, Behavioral Research, Therapeutic Approaches* **9**:110, Springer, New York, 1967.

MANUEL SCHWARTZ
HEARING REHABILITATION
321 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201
DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION
Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

MERCEDES-BENZ
Baltimore's only Authorized Dealer
for Sales, Service and Parts
R. & H. Motors, Inc.
4810 Belair Rd. 426-9200
Baltimore, Md. 21206



Renal Biopsy

Until comparatively recent times the pathologist has been dependent on material obtained at autopsy to formulate his ideas on renal disease. With few exceptions, this, of necessity, represented end-stage disease, and a good deal of speculation and clairvoyance was required to determine the sequence of events in the evolution of a given disease.

The renal biopsy has afforded us the opportunity of studying the early stages of renal disease, as well as allowing us to study the non-lethal diseases that affect the kidney. The early biopsies were obtained at the same time as operation for the relief of hypertension—usually sympathectomy—but the information from these was confined to a study of vascular changes in hypertension. The needle biopsy was introduced by Perez Ara [1] and by Iversen and Brun,[2] and since those early days many thousands of needle biopsies have been performed with low morbidity and mortality in a wide variety of conditions.

ROBERT H. HEPTINSTALL, MD
Director, Department of Pathology
The Johns Hopkins University School of Medicine

The needle biopsy is usually performed by the internist, and the technical details need not concern us in this short article. Let it suffice to say that the procedure is carried out with a Vim-Silverman needle or modification thereof, with the conscious patient in the prone position. Certain contraindications ought to be appreciated, chief among which are the presence of only one kidney, severe bleeding diathesis, suspected malignancy, and very high blood pressure. The last of these is probably a relative contraindication, for biopsies have been performed in severe hypertension with no untoward effects. Severe acute renal failure is considered a contraindication by some, but there are many instances of successful biopsy being performed in this state.

The material obtained should be fixed immediately, and buffered formalin or Helly's fluid are both acceptable. The tissue should be treated with care and not processed with the uterine fibroids and other large pieces of tissue. Paraffin sections should be cut as thinly as possible, and while many claim that two micron sections are necessary, accurate diagnosis can be made on more easily attainable four micron sections. Sections are stained with hematoxylin-eosin and many other stains if required. A small piece can be removed from the main cylinder of tissue for processing for electron microscopy. This is usually fixed in glutaraldehyde and then in osmium tetroxide, prior to embedding in one of the epoxy resins. Fluorescence microscopy to demonstrate immunoglobulins, beta 1C globulin (a component of complement), and fibrogen can also be used, but an additional piece of tissue is really necessary. Cutting a single cylinder of tissue for light, electron, and fluorescence microscopy usually leads to traumatization of the tissue, or to the frustration of having processed material with no glomeruli present.

The reason for performing a renal biopsy is to establish a definite diagnosis. This is desirable for many reasons. In the first place, it enables one to

institute rational therapy. For example, in the nephrotic syndrome, a patient with "minimal change" lesion (lipoid nephrosis) might be expected to respond to steroid therapy, whereas a patient with a virtually identical clinical picture, but with the biopsy showing idiopathic membranous glomerulonephritis, will not. Second, some idea of prognosis may be obtained, the long term prognosis of lipoid nephrosis being better than that of idiopathic membranous glomerulonephritis. In a patient with sudden onset of renal failure, the biopsy will enable one to differentiate between the florid forms of glomerulonephritis and acute tubular necrosis; in the former, long term dialysis or transplantation will prove necessary, whereas in the latter, conservative therapy or short term dialysis may be life saving. Third, the pathology of non-fatal disease may be studied; e.g., some of the cases of benign recurrent hematuria have been shown to be associated with a focal form of glomerulonephritis, a similar pathological picture also being found as the renal manifestation of Schönlein-Henoch Syndrome. Finally, it is only by the extended use of the renal biopsy that we are likely to learn about the natural history of renal disease. Already great insight has been gained into the evolution of acute poststreptococcal glomerulonephritis and systemic lupus erythematosus.

Electron microscopy and immunofluorescent techniques have revealed features of disease, as yet not fully appreciated; e.g., in idiopathic membranous glomerulonephritis, the apparent basement thickening is really an accumulation of material outside the basement membrane proper. The electron dense deposits on the outside of the lamina densa, seen in the poststreptococcal glomerulonephritis, the so-called humps, have been defined with certainty by electron microscopy, although it should be remembered that the careful pathologist had noticed them with light microscopy. More importantly, the deposits have been shown to correspond to the nodular foci of fluorescence using tagged antibody to immunoglobulins and beta 1C globulin, strongly suggesting that they represent antigen-antibody complexes. Other important concepts of pathogenesis are being enunciated with the aid of these techniques.

The renal biopsy, then, is an important tool for the practitioner specializing in renal disease, and for the investigator grappling with more fundamental problems. Renal biopsy should not be entertained lightly, for there is a definite morbidity, greatest among those who only practice the method occasionally. Intelligently used, it should provide us with answers to long standing problems over the years to come.

REFERENCES

1. Perez Ara, A.: Bol. Liga Cáncer, *Habana,* **25**:121, 1950.
2. Iversen, P., and Brun, C.: *Amer J Med,* **11**:324, 1951.

VALLEYWOOD

In the Beautiful Worthington Greenspring Valleys

20 minutes from Downtown Baltimore

Come out—bring your plans, and select your homesite in this ideal location . . . where you'll get the feel of the country . . . trees . . . squirrels . . . streams to wet your feet in . . . room for the kids to ramble. Yet you'll have reliable sewer service, water and gas, and good schools, just as though you'd brought all the good things of city life with you!

•

Off North side of Timonium Road, via Forest Ridge Road, between Five Farms Golf Course and Timonium Fairgrounds (W. of York Rd.)

•

½ ACRE WOODED HOMESITES

BEAUTIFUL ELEVATION

ALL CITY UTILITIES, INCLUDING SEWER AND WATER

COLONIAL OR CONTEMPORARY HOMES CUSTOM BUILT TO YOUR FAMILY'S NEEDS

WRITE OR CALL FOR INFORMATION

Strutt & Poole, Inc.

BUILDERS—REALTORS—DEVELOPERS

252-1900

2130 Pine Valley Drive

LUTHERVILLE—TIMONIUM POST OFFICE 21093



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Advances in Medical Libraries

On receiving our copy of the *University of Virginia Medical Center Serial Holdings* with the promise that it is the first stage in a project which will produce a list of serial holdings of all the major, medically-oriented libraries in Virginia, we were reminded of our debt to the computer which is making all this possible. Of course, the computer was assisted by library personnel and by federal resource grants under the Medical Library Assistance Act of 1965. After the recognition has been given to all involved, those who search for information and seek to obtain it can join in a quiet cheer for the progress that is being made in this area. Virginia may be one of our closest sources, but New York city is not really very far, and there, with the help of the *Union Catalog of Medical Periodicals* of the Medical Library Center of New York, may be located 25,000 medical and paramedical periodicals held by 70 libraries in the New York metropolitan area. A bonus is found in the fact that the Virginia project is based on the New York catalog and follows the same rules of entry and bibliographical form, which makes life easier for all who use the reference tools. Happy hunting!

International and American Library Meetings—1969

The International Congress for Medical Librarianship met in Amsterdam, Holland, in May, and the Special Libraries Association, which includes United States and Canadian libraries, met in Montreal, June 1-6, 1969. The Congress brought together librarians from all over the world, all with the prime purpose of pooling ideas for improving medical libraries and services universally. Special Libraries Association brings the subject closer home and promotes cooperation between all fields in special librarianship. Subsequent issues will enlarge on these proceedings.

* * *

NEW ACCESSIONS—BOOKS
(Arranged by author and title)

American Hospital Association
Cumulated index of hospital literature, 1960-64. Chicago, 1966.

American Medical Association
Medical School Alumni, 1967. Chicago, American Medical Association, 1968.

American Medical Association. Dept. of Mental Health
Narcotics addiction: official action of the A.M.A. Chicago, A.M.A., 1963.

American Medical Association. Dept. of Survey Research
Survey of medical groups in the U.S., 1965. Chicago, A.M.A., 1968.

AMA National Conference on Infant Mortality, San Francisco, Aug. 12-13, 1966.
National Conference on Infant Mortality, proceedings. Chicago, A.M.A., 1967, **AMA News Index. v. 1.,** Chicago, A.M.A., 1968.

Bailey, Norman T. J.
The Mathematical approach to biology and medicine. London, New York, Wiley, 1967.

Baltimore (City) Human Renewal Program.
A plan for action on the problems of Baltimore's disadvantaged people, Balt., Human Research Program, 1964.

Barratt, Marcia
Foundations for movement. Dubuque, Iowa, Wm. C. Brown Co., 1968.

Brandon, Alfred N.
Selected list of books and journals for the small medical library. Medical Library Association, 1967.

Brooks, Stewart M.
Our murdered presidents: the medical story. New York, F. Fell, 1966.

Buchan, William
Domestic medicine . . . Advice to mothers. 1st Charleston ed., John Hoff, 1807.

Canadian medical directory. Toronto, Current Publications, 1969.

Carcinoma of the breast; a decade of new results with old concepts. Boston, Little, Brown, 1968.

The clinical evaluation of the dangerousness of the mentally ill. Springfield, Ill., C. C. Thomas, 1967.

College of American Pathologists. **Systemized nomenclature of pathology.** 1st ed., Chicago, 1965.

Conference on Aging, 14th. University of Michigan, 1961. **Politics of age; proceedings,** Ann Arbor, Michigan, Univ. of Michigan, 1962.

Conference on cold injury. Cold injury; transactions of the 5th conference. New York, Josiah Macy, Jr. Foundation, 1957.

Conference on the Relationship of Mycoplasma to Rheumatoid Arthritis and Related Diseases, proceedings. Washington, U.S. Public Health Service, 1966.

Craniofacial anomalies; pathogenesis and repair. Philadelphia, Lippincott, 1968.

Dawes, Geoffrey S.
Foetal and neonatal physiology; a comparative study of the changes at birth. Chicago, Year Book Medical Publishers, 1968.

Denecke, Hans Joachim
Plastic surgery of head and neck. Springer—Verlag, New York, 1967.

Derian, Paul S.
An outline of orthopedic surgery. Springfield, Ill., Thomas, 1968.

Durling, Richard J.
Catalogue of sixteenth century books in the National Library of Medicine. Bethesda, Md. U.S. Dept. of Health Education and Welfare, 1967.

Eagles, Eldon L.
Hearing sensitivity and ear disease in children. St. Louis, Laryngoscope, 1967.

Elliott, Maurice W.
An experience in developing an extended care unit at Baptist Memorial Hospital, Memphis, Battle Creek, Mich. W. K. Kellogg Foundation, 1968.

Everett, Houston Spencer
Female urology. New York, Harper & Row, 1968.

Freeman, Joseph T.
Clinical features of the older patient. Springfield, Ill., C. C. Thomas, 1965.

Garb, Soloman
Disaster handbook, New York, Springer Pub. Co., 1964.

Hirschfelder, Arthur Douglas
Diseases of the heart and aorta. Phila., Lippincott, 1918.

Hollinshead, William Henry
Anatomy for surgeons. New York, Harper & Row, 1968.

Howe, A. Jackson
A Practical and systematic treatise on fractures and dislocations. Cincinnati, John M. Scudder, 1883.

Huhner, Max
The diagnosis of sexual disorders. Phila., F. A. Davis, 1942.

Huxley, Thomas H.
Man's place in nature. New York, Hurst and Company, n.d.

International Congress on Nutrition, 5th.
Panel papers-preprints, Washington, n.d.

International Symposium on the Chemical physiology of Mucopolysaccharides, Milan, 1965.
The chemical physiology of mucopolysaccharides, Boston, Little, 1968.

Johnson, Wingate Memory
The older patient, New York, P. B. Hoeber, 1960.

Joint Commission on accreditation of Hospitals
Provisional draft: standard for hospital accreditation, Chicago, Joint Commission on Accreditation of Hospitals, 1968.

Jornada Medica Nacional, 21 al 27 de abril, 1968
Primera jornada medica nacional, programa cientifica, Instituto Mexicano del Seguro Social, 1968.

Koss, Leopold G.
Diagnostic cytology and its histopathologic bases. Phila., Lippincott, 1968.

Lewis, Thomas
Clinical Electrocardiography. New York, Paul B. Hoeber, 1919.

Lilienfeld, Abraham M.
Cancer Epidemiology; methods of study, Baltimore, Johns Hopkins Press, 1967.

Lloyd, J. N.
Biographical sketch of Professor John M. Scudder, M.D. Cincinnati, Eclectic Medical Journal, 1895.

Loutitt, Richard T.
Bibliography of translations in the neural sciences 1950-60. Chevy Chase, Md., National Institute of Mental Health, 1967.
McGill University Conference on Depression and Allied States, Montreal, March 19-20, 1959. Montreal, Canadian Psychiatric Association, 1959.

Macy Conference on Negroes for Medicine. Baltimore, Johns Hopkins Press, 1968.

Maryland—D.C. Nursing Home Association
Membership directory and buyer's guide, 1969. Kensington, Md. The Association 1969.

Maryland Psychological Association. Membership directory, 1969. Towson, Md., Maryland Psychological Association, 1969.

Maryland State Department of Education. Division of Vocational Rehabilitation. Annual Report, 1968. Baltimore, 1968.

Maryland State Department of Health
Population estimates of Maryland, July 1, 1967. Baltimore, 1968.

Maryland State Department of Health. Division of Medical Facilities Development
Directory of licensed nursing homes. Baltimore, 1969.

Mathiasen, Geneva
Planning homes for the aged. New York, F. W. Dodge Corp., 1969.

National Advisory Council on Nursing Home Administration
Proposed model state law for the licensing and registration of nursing home administrators. Washington, 1968.

National Association for Mental Health
Handbook for psychiatric aids. 2 vols. New York, National Association for Mental Health, 1946-50.

National Conference on Air Pollution, Washington, D.C. Proceedings of the third conference, 1966. Washington, U.S. Dept. of Health, Education and Welfare, Public Health Service, Division of Air Pollution, 1966.

National Conference on Methadone Treatment, 1st Rockefeller University, 1968.
Proceedings of the First National Conference on Methadone Treatment held at the Rockefeller University, New York, June 21-22, 1968.

National Council on Crime and Delinquency. Council of Judges
Guides to the judge in medical orders affecting children. New York, National Council on Crime and Delinquency, 1968.

National Research Council. Office of Scientific Personnel.
Careers of PhD's, academic versus non-academic, a second report on follow-up of doctorate cohorts 1935-1960. Washington, National Academy of Sciences, 1968.

Occupational outlook handbook 1968/69 Washington, 1968.

Osler, Sir William
The principles and practice of medicine, 17th ed. A. McGehee Harvey, ed. New York, Appleton, 1968.

Pardee, Harold E. B.
Clinical aspects of the electrocardiogram including the cardiac arrhythmias. 4th ed. rev. New York, Paul B. Hoeber, 1941.

Paul, Benjamin D. ed.
Health, culture and community, case studies of public reaction to health programs. New York, Russell Sage Foundation, 1955.

Prolonged Pharmacotherapy and the eye, Buffalo, N.Y., Oct. 21 and 22, 1966
Prolonged pharmacotherapy and the eye, a symposium held under the auspices of the State University of New York at Buffalo, N.Y. Oct. 21 ad 22, 1966. Irvington, N.J. Physicians Postgraduate Press, 1968.

Redys, John J.
Improved dry-swab transportation for streptococcal specimens. Washington. U.S. Public Health Service, 1968.

Reflections on research and the future of medicine: a symposium and other addresses. Edited by Charles E. Lyght. New York, Blakiston Division, McGraw-Hill, 1967.

Scudder, John Milton
The principles of medicine. Cincinnati, Moore, Wilstach and Baldwin printers, 1867.

Sex Information and Education Council of the U.S.
Film resources for sex education. New York, Siecus Publications, 1968.

Sherman, William Bowen
Hypersensitivity; mechanisms and management. Philadelphia, Saunders, 1968.

Springer, Henry A.
Professorial views on appendicitis: educational trends. Cincinnati, the author, n.d.

Strauss, Maurice B.
Familiar medical quotations. Boston, Little, 1968.

Tibbitts, Clark
Aging in today's society. Englewood Cliffs, N.J., Prentice-Hall, 1960.

Texter, Clinton, et al.
Physiology of the gastrointestinal tract. St. Louis, Mosby, 1968.

Top, Franklin H.
Control of infectious diseases in general hospitals. New York, American Public Health Association, 1967.

Toward a definition of schizophrenia, tenth annual meeting of the Group Without a Name (Psychiatric Research Society) held at Cincinnati, March 10-12, 1967. Irvington, N.J. Physicians Postgraduate Press, 1968.

Turner, Clair Elsmere
Personal and community health. 13th ed. Saint Louis, Mosby, 1967.

U.S. Dept. of Labor. Manpower Administration
Technology and manpower in the health service industry, 1965-1975, Washington, U.S. Dept. of Labor, 1967.

U.S. Food and Drug Administration
New drug regulations under the federal food, drug and cosmetic act. Washington, U.S. Dept. of Health, Education and Welfare, 1964.

U.S. Food and Drug Administration
Selected technical publications, January—June 1967. Washington, U.S. Dept. of Health, Education and Welfare, 1967.

U.S. Library of Congress. National Referral Center for Science and Technology
A directory of information resources in the United States: Federal Government. Washington, Library of Congress, 1967.

U.S. National Cancer Institute
Reading on cancer: an annotated bibliography prepared by the Research Information Branch, National Cancer Institute, Washington, U.S. Public Health Service, 1968.

U.S. National Center for Chronic Disease Control. Heart Disease and Stroke Control Program
Selected references on rheumatic fever, glomerulonephritis and streptococcal infections: bibliography compiled from the English language, 1965, Washington, U.S. Public Health Service, 1968.

U.S. National Center for Chronic Disease Control. Heart Disease and Stroke Control Program
Selected references on rheumatic fever, glomerulonephritis and streptococcal infections: bibliography compiled from the English language, 1966, Washington, U.S. Public Health Service, 1968.

U.S. National Institutes of Health. National Institute of Allergy and Infectious Diseases
The biological properties of etiocholanolone. Combined Clinical Staff Conference at the National Institutes of Health, Bethesda, Md. National Institutes of Health, 1967.

United States of America Typhus Commission. Collected reprints nos. 1-70. 1943-47. Washington, War Department, n.d.

U.S. Treasury Dept. Bureau of Narcotics
Prescribing and dispensing narcotics under the Harrison narcotic law. rev. Sept. 1963. Washington, Treasury Dept., 1964.

The world almanac and book of facts
New York, The Newspaper Enterprise Assoc., 1969.

World nutrition surveys
Washington, Public Health Reports, 1960.

World who's who in science
A biographical dictionary of notable scientists from antiquity to the present. Chicago, Marquis—Who's Who, 1968.

Wynder, Ernest L.
Toward a less harmful cigarette, a workshop held at the World Conference on Smoking and Health, Sept. 11-13, Bethesda, National Cancer Institute, 1968.

Year book of drug therapy
Chicago, Yearbook Medical Publishers, 1969.

RESERVE SEPT. 4-6
FOR THE FACULTY'S
SEMIANNUAL MEETING IN
HERSHEY, PA.
PLAN TO ATTEND!



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of th weight-control program *you* recommend. reduces the appetite. Doesn't kill it. Weigh loss is significant—gradual—yet there is relatively low incidence of CNS stimula tion. Because TEPANIL works on th appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in patient hypersensitive to this drug; in emotionally unstable patient susceptible to drug abuse.

Warning: Although generally safer than the amphetamine use with great caution in patients with severe hypertension severe cardiovascular disease. Do not use during first trimester pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of the apy, unpleasant symptoms with diethylpropion hydrochloride have been reporte to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has bee reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordi pain, arrhythmia, palpitation, and increased blood pressure. One published report describe T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydr chloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythem

Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discon fort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depressio agranulocytosis, and leukopenia.

A variety of miscellaneous adverse reactions have been reported by physicians. These includ complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pai decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowe whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour befo meals. If desired, an additional tablet may be given in midevening to overcome night hunge Use in children under 12 years of age is not recommended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/69



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Rehabilitation of Patients Suffering from Fracture of the Hip*

Part I: Introduction and General Considerations

The need to rehabilitate patients suffering from fracture of the hip is of utmost importance to the patient, his family and his physician.

The cause is usually an accident, thus, a sudden, unplanned event. Frequently, complications compound an otherwise simple problem; as other injuries may accompany the hip fracture. In many elderly patients, the events may be poorly tolerated because of the precipitation of generalized metabolic, nutritional, psychological, and physiological decompensations.

JOHN D. HSU, MD
Div. Orthopaedic Surg., Dept. Surg.
Baltimore City Hospitals and
Johns Hopkins Medical Institutions

Objectives

The object of rehabilitation is to have the patient become as independent as possible and yet to protect the affected lower limb. The ideal situation would be to restore the patient to his previous and pre-injury state and condition. However, this may not always be possible.

At the time of hospitalization, two goals need to be considered: They are:

1. The discharge from the hospital; and 2. The maximum amount of independence that can be attained by the patient.

The former is achieved by discharge planning and consideration of the problems of after-hospital care. Arrangements have to be made with the patient, his family, and his relatives. The help of members of his community may be needed. The social service department should be given an active part. The physician-in-charge sets up guidelines and advises on all phases necessary to make the problem better understood by all concerned.

The amount of independence allowed may depend on the various medical factors, of which the physician's assessment of the stability of the fracture fixation is very important. With careful follow-up, it is hoped that improvement will continue, making the rehabilitative regimen progressive until the fracture has healed sufficiently and satisfactorily so that the patient can once again resume as much of his pre-injury activities as possible.

The Team Approach

In the planning of rehabilitation, a multi-disciplinary approach should be taken. This is especially necessary in the older age group where the need for "Teamwork" and understanding of the problems by interested persons and their staffs is vital. The problems will involve the following services and their respective members.

I. The medical staff, the physician-in-charge, his consultants, and members of the hospital house-staff.

* *Supported in part by an American Geriatrics Society Award and USPHS Grant No. 5T1 GM00624-08.*

II. The nursing staff; the head nurse on the ward, her nursing personnel and para-nursing personnel.

III. Physical therapy department with the physiatrist acting as the consultant, his staff of physical and occupational therapists.

IV. Social service department.

V. Rehabilitation counselors, community services and other interested para-medical and voluntary personnel.

The integration of all the different disciplines will provide better over-all care for the patient. This ensures better communication between services to avoid confusion and the duplication of efforts. Such an approach may facilitate the understanding of the patient's disability by the medical and nursing professions as well as paramedical personnel.

Certain problems involving the different disciplines may be minor in certain patients but can become a major factor in others. As an example, in younger patients, better communication, reassurance, and temporary financial relief for the family may be necessary. On the other hand, a patient in the older age group may be more apprehensive, require more supervision of his activities, more help and training in physical therapy to get about, or may require certain aids and more integrated medical care for rehabilitation over a longer period of time.

The relationship between members of the rehabilitation team can be as loose or as close-knit as the attitudes of different persons will allow, but one should not forget that the concept of the attending physician-in-charge, and his responsibility to his patient should still be recognized as the basic principle of such management.

The Important Role of the Physical Therapy Department in the Rehabilitation Program

The physical and occupational therapists play a very important role in helping the patient gain independence.[1] The need for a person to move about is important. A patient recumbent in bed, because of trauma or disease, is prone to develop negative nitrogen balance.[2] Being able to get the patient out of bed not only helps with nursing care but it also contributes to better breathing.[3] Active exercises to keep the muscles of the body from disuse are important, although atrophy is not a major factor if therapy is instituted early. The gradual placing of the patient in an upright position using a tilt-table after a period of recumbency helps physiological adjustments and can be the start of a progressive program whose rationale is one of decreasing dependency geared to individual needs.[4]

The teaching of the maintenance of balance is especially important in an elderly, apprehensive person. If this is achieved, then rapid progress can be made. Balancing and walking aids are most helpful when they are properly selected and perhaps even adapted to certain conditions.[5, 6] The Physical Therapy objectives as described by Patton et al,[7] and Hirschberg [8] and the regimen followed by Cocchiarelli and Yue [9] to restore function and improve the patient's well-being, are examples of the progressive nature of the program that is in common use today. The Occupational Therapy goal, described by Riccitelli,[10] to "promote the social welfare of the aged person by retraining them to their highest possible level of mental and physical activity . . ." deserves consideration.

Evaluation

A regimen of progressive rehabilitation requires an evaluation of the patients' capabilities from a rehabilitative standpoint. Postoperative clinical assessment with periodic radiographic examinations for the maintenance of fracture position and the demonstration of the laying down of callous by the healing tissues, interpreted in the light of our current scientific knowledge of the healing of fractures, are important.[11] In addition, tests for the capability of carrying out postoperative rehabilitation activities and assessment of the mental and emotional capacity of the patient must be taken into account for the setting up of realistic goals. At the Baltimore City Hospitals, we have combined the Mental Status Check List (MSCL),[12] following Lifshitz's [13] principles and the Activities of Daily Living (ADL)[14] tests as an aid in the planning of a rehabilitative program to follow the progress and to make changes in the treatment program.

REFERENCES

1. Isaacs, Bernard: *An Introduction to Geriatrics.* Baltimore: Williams and Wilkins Co., 1965.
2. Treister, B. A.: "Physical Medicine and Rehabilitation in Geriatrics." *Phys. Therapy Rev.,* **30:** 411, 1950.
3. Rose, D. L., Shires, E. B., and Alyea, W. S.: "Physical Measures in the Aged." *JAMA,* **162:**1524, 1956.
4. Waugh, J. W.: "Objectives of Physical Medicine and Rehabilitation in a Chronic Disease and Geriatric Facility." *J. Amer. Ger. Soc.,* **10:** 522, 1962.
5. Grant, W. R.: Principles of Rehabilitation. Edinburgh: E. & S. Livingstone, 1960.
6. Westhoven, M. F.: "Adapted Parallel Bars." *J. Am. Phys. Therap. Assn.* **41:** 120, 1961.
7. Patton, F., Behlow, D. and Pechalt, P.: "Treatment of Hip Fractures in the Geriatric Patient." *J. Am. Phys. Therap. Assn.* **42:** 314, 1962.
8. Hirschberg, G. C., Lewis, L. and Thomas, D.: *Rehabilitation. A Manual for the Care of the Disabled and Elderly.* Philadelphia: J. B. Lippincott Co., 1964.
9. Cocchiarelli, A. and Yue, S. J.: "Rehabilitation of Geriatric Patients with Hip Fracture." *J. Amer. Ger. Soc.,* **14:** 1172, 1966.
10. Riccitelli, M. L.: "The Modern Concept of Occupational Therapy in the Rehabilitation of the Aged." *J. Amer. Ger. Soc.,* **12:** 1002, 1964.
11. Pritchard, J. J.: "Histology of Fracture Repair." *Modern Trends in Orthopaedics,* **4:** 69, 1964.
12. Carroll, D. G.: "Measurement of Performance in Rehabilitation. Orientation." *Md. State Med. J.,* **17:** 127, 1968.
13. Lifshitz, K.: "Problems in the Quantitative Evaluation of Patients with Psychoses of the Senium." *J. of Psych.,* **49:** 295, 1960.
14. Carroll, D. G.: "Measurement of Performance in Rehabilitation. Activities of Daily Living (ADL)." *Md. State Med. J.,* **17:** 113, 1968.

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass
cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.

New Professional Practitioner:

The Pediatric Associate

Two of the nation's larger philanthropic foundations, Carnegie Corporation of New York and the Commonwealth Fund, recently announced support of an experimental program to prepare a wholly new type of professional practitioner in medicine: a Pediatric Associate who, working under the supervision of a physician, will be qualified to examine and immunize well children and treat the more common childhood diseases.

The purpose of the project is to demonstrate one new method of providing more and better care to our nation's burgeoning child population in spite of the national shortage of pediatricians and others who care for children. The project will be conducted by the University of Colorado School of Medicine, under the direction of Dr. Henry K. Silver, professor of pediatrics and chief architect of the new curriculum. Graduates of the program will receive a bachelor of arts degree from the University of Colorado.

The Role of the Pediatric Associate

The responsibilities envisioned for graduates of the curriculum—who will be termed Pediatric Associates—are based not on the nursing role, but on the physician's role. Hence, the associate will have a substantial degree of medical responsibility for the physician's patients.

The associate will make diagnoses and decide on and carry out appropriate measures for treatment. This will include the writing of prescriptions—exclusive of narcotic compounds—from an approved list of drugs. Thus, the associate will be equipped to take part in all dimensions of the physician's practice. The same wide level of responsibility will apply to associates employed under doctors in the public-health services.

The limits of the associate's medical-practice activities, however, will be clearly defined both legally and professionally.

With the backing of the Colorado State Medical Society, the State Chapter of the American Academy of Pediatrics, and other responsible medical bodies, legislation has been proposed setting forth the terms governing the required education and permissible scope of activities of this new health professional. The legislation will require that graduates of the associates curriculum be examined and certified by the Colorado State Board of Medical Examiners.

Design of the Experimental Curriculum

The experimental curriculum has been designed to lead to professional qualification five years after high school, including a year of internship. It is a joint program between the university's main campus in Boulder and the School of Medicine in Denver. The university and the school have assigned leadership in the effort to the Department of Pediatrics, and an advisory committee with representation from Colorado medical societies and state and local government health agencies has been appointed to guide the Department in development of the curriculum.

Students interested in the program will spend their first two years of the five-year course at Boulder—or other undergraduate schools of their choice—taking liberal arts offerings and essential premedical studies, such as organic chemistry, biology, and mathematics. Dr. Silver, director of the program, and other members of the faculty, will keep in touch with them during this period, working with the student-counseling staff of the University of Colorado and conducting seminars on broad aspects of medical practice.

Students accepted for training as Pediatric Associates will transfer to the University of Colorado Medical Center for three years of intensive professional education.

The first year of the professional-education phase will be devoted to a concentrated, 48-week sequence of studies in the basic sciences. The emphasis here will be on the relevance of these fields to understanding both the normal and the disease states of physiological systems. For example, anatomy and physiology will be combined in the study of the cardiovascular system, and will be followed by combined studies of heart and vascular pathology and related clinical diagnoses.

The second year, also 48 weeks, will be devoted to fundamental clinical training and will consist of a clerkship experience similar to that provided for medical students. Along with medical students, the students in the Pediatric Associate course will gain

experience in history taking, performing complete physical examinations, and in ordering, carrying out, and evaluating pertinent laboratory studies. They will also participate with medical students in Departmental conferences, seminars, and rounds. The main difference between the Pediatric Associate clerkship and the medical-student clerkship is that the Associate's training will concentrate largely on the elements of health care as limited to children, and will give particular attention to ambulatory pediatrics.

These emphases will also characterize the Associate's internship training, the final year of professional education. For this purpose, a broad array of teaching settings are available—including not only the outpatient departments and special clinics of the University's Medical Center and of the Denver Department of Health and Hospitals, but also sizable O.E.O. Neighborhood Health Centers and their satellite health stations.

In addition, during their internship, the students in the Associates course will train in the offices of pediatricians in private practice, who will serve as their preceptors.

Another chief feature of the associate's professional education will be attention throughout the course of child development and growth, and family and community life as they affect behavioral patterns in health and illness.

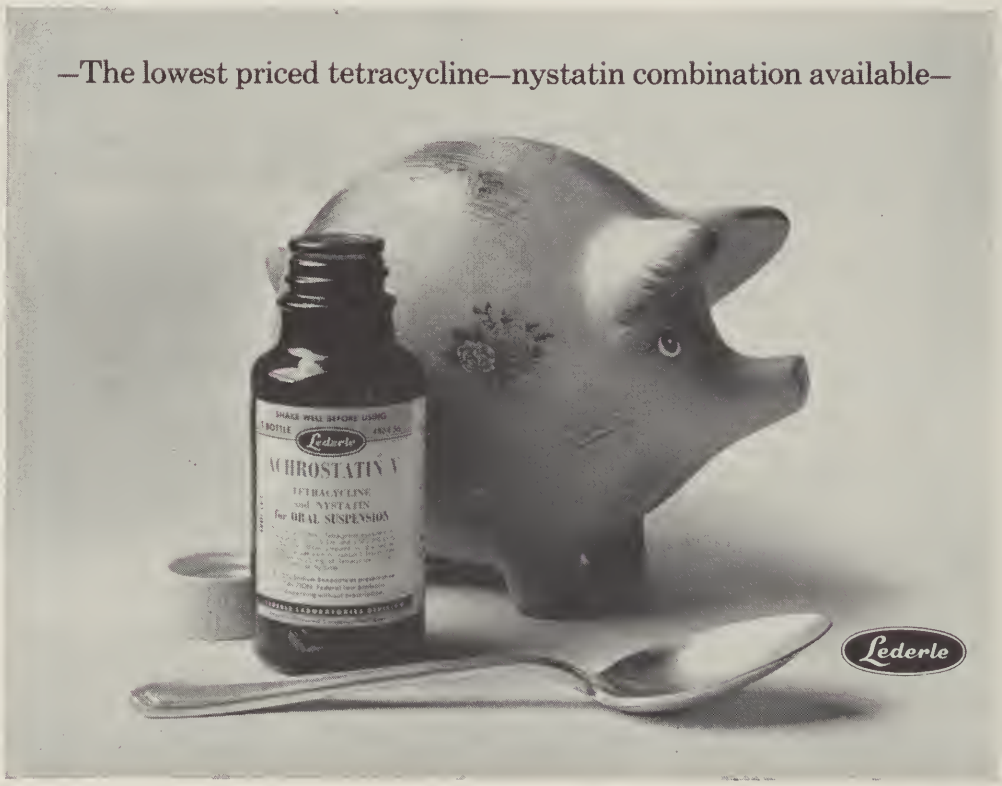
DO YOU NEED



If you are a doctor or dentist or supervise a staff in a hospital or nursing home, there are times when you have wished that help was a phone call away. Now it is. Call us night or day for the nursing or medical office employees you need. Our service is national, our employees are experienced, screened, insured and bonded.

MEDICAL PERSONNEL POOL
Washington—Phone 667-6345
Baltimore—Phone 685-5053

—The lowest priced tetracycline—nystatin combination available—





A Service of the Tuberculosis Association of Maryland

tuberculosis

Childhood Sarcoidosis

In a series of 18 cases of sarcoidosis in children, outcome of the disease was more favorable in those who were asymptomatic at the time of diagnosis than in those who had symptoms. Sarcoidosis may be more prevalent in children than has been estimated.

Sarcoidosis is rarely diagnosed in children in an early stage. One reason is that children are not usually included in chest X-ray surveys which may lead to the discovery in adults of the clinically silent, early intrathoracic sarcoidosis. By the time sarcoidosis is recognized in children it may be advanced, with one or more extrathoracic components.

In a study of 18 cases of proved sarcoidosis in children, the outcome of the disease was found to correlate largely with the presence or absence of symptoms at diagnosis.

In age the children ranged from 9 to 15 years. Eleven were boys, seven were girls. The disease was symptomatic at the time of diagnosis in 11; asymptomatic in seven. All children 12 years of age and under, but only six of those 13 to 15 years of age, had symptoms at the time of diagnosis.

Seven of 11 children with symptoms already had chronic disease, and the disease in five of the seven asymptomatic children was in the subacute stage. Extrathoracic involvement had occurred in all the children with disease in the chronic stage, but only three of the asymptomatic children had such involvement.

Two of the children had normal X-ray films initially; the others had hilar adenopathy either alone (3) or with pulmonary mottling or mottling alone (13). Five of the children with hilar adenopathy and pulmonary mottling showed flocculent infiltrations; five had miliary nodules, and three had focal streaking. In one child who had parenchymal densities without hilar adenopathy, the lung pattern was diffusely reticular.

Eight of the *symptomatic* children had hilar adenopathy with pulmonary mottling. Two children with extrapulmonary sarcoidosis had a normal chest film. Three children with no symptoms at onset showed hilar adenopathy alone, and four others showed hilar adenopathy and pulmonary mottling.

Presenting Signs

Enlargement of the peripheral lymph nodes was the presenting sign in four of the 11 children with symptomatic onset. In three others, dimness of vision in one eye was the first sign. Signs in the other children were respiratory symptoms, weight loss, erythema nodosum, and parotid enlargement.

The Kveim test was positive in 16 of the 18 chil-

Louis E. Siltzbach, MD, and Gerald M. Greenberg, MD. *The New England Journal of Medicine,* December 5, 1968.

dren. Both children in whom it was negative had had sarcoidosis for more than three years when the Kveim test was applied. Diagnosis was confirmed by biopsy. Eleven children in all had organ biopsies.

All but two children had negative tuberculin tests, which is common in sarcoidosis. The two positive reactors responded only to second-strength PPD.

Ten children received drug therapy consisting of daily doses of either prednisone (or an equivalent hormone) or chloroquine; two of the 10 received both drugs at different times.

Observation Period

Seventeen of the children were observed for periods ranging from one to nine years (a mean of three and one-tenth years). At the end of the observation period, activity had subsided and all lesions had cleared in five, four of whom had been asymptomatic at onset. Ten other children improved, but clearing was not complete. Only two children, both with symptomatic onset, became worse.

Improvement, but not clearing of lesions, was observed in 14 of the 17 children during the *first* year, and was maintained in all but one of these. The remaining patient in this group developed bilateral nerve deafness in the second year. One child who became worse in the first year later lost the sight of one eye.

The course and outcome were distinctly less favorable for children with symptomatic onset than those who were asymptomatic and whose disease was detected by mass surveys or routine roentgenography. Six of seven asymptomatic children, all 13 years or older at the time of diagnosis, were clinically well when last observed.

However, of the 11 symptomatic children, only two were entirely well, and nine had varying grades of disease activity. Temporary improvement did occur spontaneously or with therapy in all the 11 children. Corticosteroid therapy helped control recent lesions. Chloroquine was of particular value in treating cutaneous sarcoidosis. Respiratory failure has not as yet been observed in any of the children.

The discovery that asymptomatic sarcoidosis was relatively common among young adults dates back to the mass X-ray surveys of Armed Forces recruits in World War II. There has since been growing recognition that a presymptomatic stage, marked only by silent, bilateral hilar adenopathy and frequently associated with a negative tuberculin test, is more common in the general population than had been recognized. Since children have not been included in mass radiographic surveys, the prevalence of childhood and adolescent sarcoidosis has not until recently been estimated in any country. In Japan and Hungary, children are being included in such surveys and asymptomatic cases are being uncovered at a prevalence rate approaching that of adults in those two countries.

Predicting Prognosis

In the series reported, the children with symptomatic onset were younger and had more extensive disease than those whose illness was detected in the asymptomatic stage. Because of the delayed detection of sarcoidosis in children whose symptoms were already present, corticosteroid therapy was required more frequently and for a longer time than it was for the asymptomatic group. The prognosis was also less favorable for the symptomatic child. Prognosis could be predicted with a fair degree of accuracy by the end of the first year of observation.

Thus, it appears that sarcoidosis may come and go unrecognized in children, especially in those approaching adolescence, and that the disease is more frequent in children than had been estimated.

A possible diagnosis of sarcoidosis should be considered in children with unexplained mediastinal or superficial lymphadenopathy, hepatosplenomegaly, uveitis, enlargement of the salivary or lacrimal glands, cystic bone lesions of the hands or feet, lung infiltrations or granulomatous skin lesions. Organ biopsy, Kveim test and appropriate radiography can lead to early diagnosis, after which proper therapy can be instituted, with the prevention of some of the irreversible organ damage.

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery MU 5-3232

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202

SKILL SURGICAL, INC.

S K I L L

SUPPLIES & EQUIPMENT
for
PHYSICIANS—SURGEONS
HOSPITALS

5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

What makes a

A man?
Another woman?
Three kids?
No kids at all?
Wrinkles?
You name it.

Is she truly depressed?

Is that why she lets go in your office?

You comfort her.
Talk to her.
And, if she is depressed, consider Pertofrane.
Because in 3 to 5 days she can often begin to cope, work, maybe play, even enjoy.

Pertofrane®

desipramine hydrochlorid
In depression...
when words are not enoug

But before you prescribe Pertofrane, please see the full prescribing information and especially note Contraindications, Precautions, Warning, Adverse Reactions and Dosage. A brief summary of that information is included here.

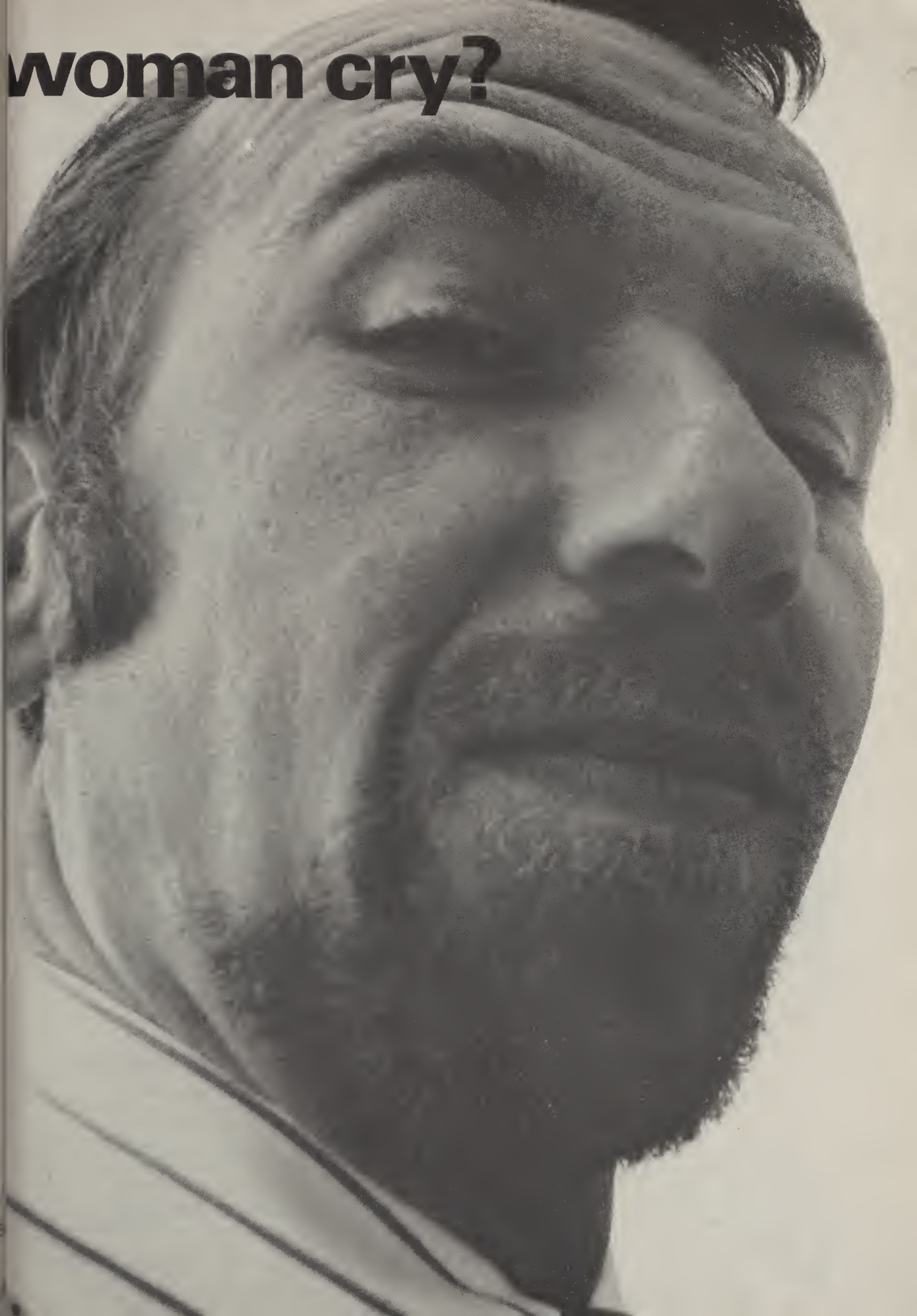
Pertofrane® desipramine hydrochloride

Indications: For relief of depression.
Contraindications: Do not use drugs of the M.A.O.I. class with Pertofrane. Hyperpyretic crises or severe convulsive seizures may occur; potentiation of adverse effects can be serious or even fatal. When substituting this drug in patients receiving an M.A.O.I., allow an interval of at least 7 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.
Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Do not use in patients under 12 years old, and do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk.
Precautions: Careful supervision and protective measures for potentially suicidal patients are necessary. Discontinuation of therapy or adjunctive use of a sedative or tranquilizer may be necessary in the presence of increased anxiety or agitation, hypomania or manic excitement. However, phenothiazines may aggravate the condition. Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents). Carefully observe patients with increased intraocular pressure. Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications. Cardiovascular complications (myocardial infarction and arrhythmias) are potential risks since they have occasionally occurred with imipramine, the parent compound. Desipramine may block the pharmacologic activity of guanethidine and related adrenergic neuron-blocking agents. Hypertensive episodes have been observed during surgery in patients on desipramine therapy.
Before prescribing the drug, the physician should be thoroughly familiar with prescribing information, with the literature, with all adverse reactions, with the diagnosis and management of depression, and with the relative merits of all measures for treating the condition.
Adverse Reactions: Dry mouth, constipation, disturbed visual accommodation, anorexia, perspiration, insomnia, drowsiness, dizziness, headache, nausea, epigastric distress, and skin rash (including photosensitization) may appear. Since orthostatic hypotension has occurred, carefully observe patients requiring concomitant vasodilating therapy, particularly during the initial phases. Other adverse reactions include tachycardia, changes in EEG patterns, tremor, falling, mild extrapyramidal activity, neuromuscular incoordination, epileptiform seizures. A confusional state (with such symptoms as hallucinations and disorientation) occurs occasionally and may require reduced dosage or discontinuance of therapy. Rarely, transient eosinophilia, slight elevation in transaminase levels, transient jaundice, or liver damage have occurred. If abnormalities occur in liver function tests, discontinue drug and investigate. Occasional hormonal effects, particularly decreased libido or impotence and instances of gynecomastia, galactorrhea and female breast enlargement have been observed. Urinary frequency or retention may occur. The drug should be discontinued if agranulocytosis, bone marrow depression, jaundice, thrombocytopenia, or purpura occur.
Dosage: 25 to 50 mg. t.i.d. The maximum daily dose is 200 mg. Continue maintenance dosage for at least 2 months after obtaining satisfactory response. Generally, elderly and adolescent patients should be given low doses.
Availability: Pink capsules of 25 mg. in bottles of 100 and 1000. (B) 46-530-E

For complete details, please see the prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

woman cry?



Find Your Place

For your next meeting, banquet or convention . . . consider



THE NEW OCEAN CITY CONVENTION HALL

One of the most beautiful facilities on the east coast—ideal for sales meetings, private parties, banquets, conventions, trade shows . . . concerts, dances and sporting events. Will accommodate up to 2000 at a banquet, 3000 at a convention; meeting rooms for 50 to 300 persons. Air-conditioned and heated—for year-round use. Large private parking area.

For complete information . . . . write
EARL G. BAIRD, *Executive Director*
4000 Philadelphia Ave., Ocean City, Md. 21842

Resort Advertisers in This Issue

Easton

Walsh and Benson 124
Helaine White 124

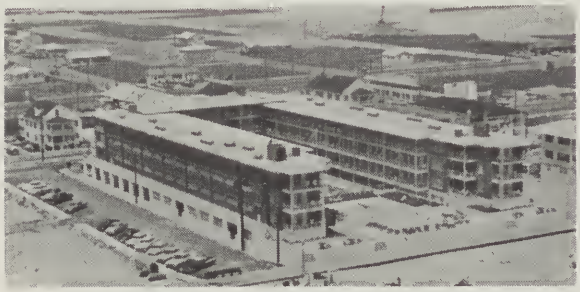
Ocean City

Convention Hall 122
Diplomat Motor Hotel 122
Mario's Restaurant 123
Stowaway Motel 123

Rehoboth Beach

Atlantic Sands Motel 122
Dinner Bell Inn and Motel 123
Stewart Kingston Galleries 123

DIPLOMAT MOTOR HOTEL



Largest, Most Luxurious Units on Beach
Bedroom and Efficiency Units

● **CONTINENTAL CUISINE** ●

Food Prepared by our Chef for
the Most Discriminating Connoisseurs

100% Air Conditioned

- Swimming Pool
- Dining Room
- Cocktail Lounge
- Coffee Shop

. . . and you get TV in every room

WE CATER TO CONVENTIONS – *Accomodations for small groups, up to 300 persons*

Boardwalk at 26th W
Telephone 289-7148

OCEAN CITY MARYLAND



For the Best in Leisure Living

Enjoy a vacation at the

Atlantic Sands MOTEL

Boardwalk and Baltimore Ave.

REHOBOTH BEACH, DELAWARE

- 80 FINE ROOMS
- HEATED POOL
- AIR CONDITIONED
- TELEPHONE SERVICE
- TELEVISION
- RESTAURANT
- BEACH SHOP
- ELEVATOR SERVICE

OPEN ALL YEAR LONG!

Write for Reservations . . . . . or
Phone **(302) 227-2511**

In the Sun

Mario's

Specializing in
ITALIAN ★ AMERICAN
FOOD
CONTINUOUS ENTERTAINMENT
IN OUR INTIMATE
Cocktail Lounge

Phone AT 9-9445
OCEAN CITY, MD.

OPEN DAILY THROUGH LABOR DAY!
Breakfast—Luncheon—Dinner
Credit Cards Honored

AT THE NATION'S SUMMER CAPITAL . . .

Dinner Bell Inn and Motel

"FAMOUS FOR FOODS"

COCKTAILS

2 Christian St., Rehoboth Beach
Delaware
Phone Area Code: 302-227-2561

Blanche Thompson at the Electric Organ
VISIT OUR UNIQUE GIFT SHOP

STUART KINGSTON GALLERIES



THE ROYAL SHAH KERMAN CARPET
Finest in all the world
Exclusively at Stuart Kingston Galleries
AUCTION SALES NIGHTLY – 8 P.M.
The First Gallery in the First State
Exhibition hours – 10 A.M. – 4 P.M.
Phone (302) 227-2524
On the Boardwalk—REHOBOTH BEACH, DEL.

The BIG One On The Ocean
Ocean City, Md.
Stowaway
MOTEL
21st to 22nd St. & BOARDWALK



"The Stowaway Has Everything"
- One full block of beautiful beach
- Air Conditioning
- Free Parking
- 120 Units, 33 Efficiencies
- Children's Pool
- Color TV Room
- Magnificent Olympic-size Pool
- Restaurant and Cocktail Lounge
- Free TV in every room
- Supervised Beach
- European Cuisine

For Reservations—Call ATlantic 9-6191



"Peach Orchard Point"

BEAUTIFUL WATERFRONT ESTATE

Beautifully located on the Miles River, just 5 miles west of Easton, this charming 7-acre estate has a spacious residence of Colonial Brick, with 4 bedrooms, 3 tile baths, living room with fireplace, "living kitchen" with attached den & fireplace, large screened porch overlooking "Peach Orchard Cove." Entire waterfront bulkheaded; 75 ft. pile driven wharf; protected anchorage adequate for most any vessel.

EXCLUSIVE AGENTS

Walsh & Benson, Inc.

REALTORS

301 – 822-1415

EASTON, TALBOT COUNTY, MD.

DROWNPROOFING

Teach your child drownproofing.

Drownproofing, according to the Health Insurance Institute, consists of a series of arm and leg movements that help a person move up and down instead of forward.

Detailed instructions for teaching this technique to youngsters are now being provided on a new wallet-sized card published free of charge by the U.S. Public Health Service.

If performed correctly, reports the PHS, it will allow a child to survive in the water for hours, even if it is rough.

The PHS card, "Safety Tips In-Out-and-Around the Water" may be obtained free in quantities up to 100 by writing to the Injury Control Program, National Center for Urban and Industrial Health, 222 East Central Parkway, Cincinnati, Ohio 45202.

OXFORD WATERFRONT



4½ acre waterfront point, 800 foot shoreline, includes vacation cottage, outbuildings, dock. Adjacent to Oxford, heart of Talbot County cruising waters, this offers A-1 investment and all the relaxation that waterfront seclusion affords. Offered at $45,000.

HELAINE WHITE, *Realtor*

Easton, Maryland (301) 822-4626



CONCORDE

The Custom Line of Fiberglas

by *Brunswick*

27′ to 47′

VENTNOR MARINE SERVICE

Ventnor Road Pasadena, Md.

255-4100

Schools teach your kids how to read and write.

We teach them how to save lives.



help us help

The American Red Cross.
We don't know where
we'll be needed next.

You don't either.

advertising contributed for the public good
ADVERTISING COUNCIL

NOW
A NEW CONCEPT
in
BOOKEEPING
and
TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

FEDERATED BUSINESS SERVICES, INC.

Box 580
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager

PIPE SMOKING AND KIDNEY CANCER

Two Seattle pathologists reported in *Cancer* that cigarette smokers are five times more likely to get kidney cancer than nonsmokers. However, the risk for pipe and cigar smokers—who usually don't inhale—is about ten times higher.



WHEN YOUR PATIENTS NEED NURSING CARE

Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED
24 HOUR SERVICE ESTABLISHED 1935
BALTIMORE, MARYLAND 21229

This is the new 144S Volvo Sedan For 1969



What a prescription for "Same-old-car-itis."

Volvo offers the most advanced safety features of any car. It's so economical it gets up to 25 m.p.g. With automatic transmission, stereo tape, air conditioning available—and world famous Volvo quality built-in, we think you'll agree the prognosis is extremely favorable.

FREE 24 HOUR DEMONSTRATION

michaelson motors, inc.

America's Largest Volvo Dealer
5801 REISTERSTOWN RD.
Open Nitely 'til 9:30 • 358-5800

The MEDICAL and CHIRURGICAL FACULTY of the State of Maryland

ACCIDENT AND HEALTH PROGRAM FOR FACULTY MEMBERS

- **ACCIDENT AND SICKNESS TOTAL DISABILITY**
- **MAJOR MEDICAL EXPENSE**
- **ACCIDENTAL DEATH AND DISMEMBERMENT**

Administered by
THE MED-CHI INSURANCE TRUST

Official Faculty Agent
B. Dixon Evander and Associates

Underwritten by
Hartford Accident and Indemnity Company

Member of
The Hartford Insurance Group
Hartford, Connecticut

For more information detach and mail slip directly to:

MED-CHI INSURANCE TRUST
1211 Cathedral Street, Baltimore, Maryland 21201

*Name*_____

*Address*_____

*City and State*_____ *Zip Code*_____



The Fortunate One.

Her urinary tract infection reveals itself through pain and discomfort.

While the pain and discomfort of a G.U. infection are anything but pleasant, the patient may be luckier than she realizes. That burning sensation (and/or frequency, urgency, dysuria) is a usually reliable sign of a urinary tract infection. And it's her good fortune that her infection won't go undetected...or untreated.

Azo Gantanol® therapy usually provides analgesic action within one-half hour, while control of the infection begins within two hours. Azo, a specific urinary analgesic, soothes inflamed mucosa to give symptomatic relief. At the same time, the antibacterial component, Gantanol (sulfamethoxazole), achieves therapeutic levels in the blood and urine, with diffusion into interstitial fluids. Azo Gantanol—a good choice when urinary tract infection reveals itself through symptomatic distress.

Before prescribing, please consult complete product information, a summary of which appears on opposite page.

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Azo for the pain
Gantanol®
(sulfamethoxazole)
for the pathogens

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

Dosage: Adults—4 tablets initially, then 2 tablets morning and evening.

How Supplied: Tablets, bottles of 50.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

BALTIMORE OXYGEN SUPPLY CO., INC.

OHIO CHEMICAL DISTRIBUTORS

Therapy and Medical Gases
and Oxygen Tents
Resuscitators and Apparatus

Main Office & Plant: Linthicum, Md. 789-8100
Warehouse: 1611 Guilford Ave., Baltimore, Md. 727-4748
Branch: 2426 Linden Lane, Silver Spring, Md. 582-2094

STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

We Repair and make Lamps
"Lamps make the home Beautiful"
LE 9-0222
403 N. Charles Street
Baltimore, Md. 21201

Why take chances.
Why not let CHERNOCK guard your valuable key records in their modern, safe, fireproof warehouse.
Surprisingly inexpensive.
CHERNOCK
MOVING & STORAGE
PHONE 685-7630

M.D.'s
or
DENTISTS
in
ASSOCIATED
PRACTICE

Up to 8,000 sq. ft. of office space, custom-finished to your specifications. Prime northwest Baltimore location. 2 min. from Sinai Hospital, Jones Falls Expwy. Ample parking space. Jitney service to nearby bus stops. Special tax advantages for resident doctors. Leasing and Management, Chas. H. Steffey, Inc. Call 685-2412 or 542-6684

GREENBERRY WOODS

NORTHERN PARKWAY AT JONES FALLS EXPRESSWAY

Wide Foundation

During his hospital training, many a resident has come to depend on the team approach to medical problems. Having no worries about the costs to the patients, the resident feels free to call for all the help he can get. When in a quandary, he has the services of innumerable consultants available.

During his training, this attitude can be for the good of the patient. As a tyro MD who may have enjoyed total scholarship aid for his education, he does not understand how much this type of medicine costs the taxpayers. Intellectual inadequacies are easily covered by the act of asking for consultation, no matter how often.

When these MDs enter private practice, there is a rude and abrupt awakening. Even after qualifying for certification in a specialty or subspecialty board, the MD can encounter problems not precisely in his field. Referring a patient with an acute otitis to an otorhinolaryngologist is one thing, but what to do with the patient with an abdominal pain is another. An urologist, gynecologist, surgeon, aller-

ABBEY RENTS
SICKROOM EQUIPMENT

Prompt, professional service 24 hours a day, every day! A complete line of hospital beds, wheelchairs, traction equipment, oxygen, crutches, walkers, commodes, lamps, whirlpools—everything to help patients get well faster.

We Process MEDICARE Equipment Claims.

358-3400
6316 Reisterstown Road
Baltimore

gist, or internist may be needed. For the newly independent MD, calling all of these physicians can at first seem easy and logical. However, when the patient asks him why so many physicians have sent him bills, the MD is forced to be concerned. Suddenly, he becomes aware of certain deficiencies in his training. Why didn't he learn which specialist to call?

Intensive knowledge in a subspecialty alone can be justified on occasion, but not at the expense of isolation from the rest of medical knowledge. Neither should the narrow limits of the super specialist cost the patient extra dollars and waste of time in finding the proper MD to care for him.

The medical educators who are seeking to rearrange the internship and residency programs should not neglect the need for a wide medical foundation upon which to build a specialty. There is no need for "quickie" specialists trained only in a narrow field. More, not less, time is needed for specialty training.

HOOD CONVALESCENT HOME

"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF

CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED

National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM

Certificate Holder—Baltimore County
Fire Prevention Bureau Award

LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800

5313 EDMONDSON AVE.

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

Geo. RADEBAUGH & Sons

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300

Baltimore's most unusual dining place!

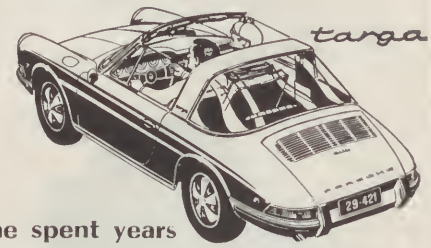
Famous
Owl Room



Belvedere Hotel
Charles & Chase Streets

Visit the #1 Spot for
Your Diet Needs
Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)
For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic
SPECIAL DIET SHOP
Phone SA 7-0383

PORSCHE



Porsche spent years developing a great competition car so you could have fun driving to work.



Both body styles available in four engines:
912 - 911T
911E - 911S

Sportomatic available on 911 series only

40 West VOLKSWAGEN
Phone: 744-2300
6624 Baltimore National Pike
West of Beltway Exit 15 on Rt. 40 West

The World's Best $2000 Car stops with disc brakes straight, quick & sure!



It's yours for only $44 a month

Front disc brakes for safety! Fully independent rear suspension for comfort. Bucket seats and dozens of other extras, too.

DATSUN / 2

All colors and models in stock for immediate delivery!

TOWN & COUNTRY MOTORS
8021 Harford Rd. Baltimore, Md. 21234
665-7500

IN THE BUILDING AND TRADITION OF THE BALTIMORE EYE EAR AND THROAT HOSPITAL



AT THE FRANCIS SCOTT KEY MONUMENT
Near Jones Falls Expressway and State Office Building

Key Circle Hospice
NURSING HOME & EXTENDED CARE FACILITY
R. W. Hansen, *Administrator*
1213 EUTAW PLACE BALTIMORE, MARYLAND 21217
523-7800
THE BEST CARE AVAILABLE
UNDER CONSTANT MEDICAL SUPERVISION
MODERATE RATES

Do Your Patients Need Nursing Service?

Call 889-5666

COBB-WOODS SERVICES

Vera Woods, M. A. Director

2213 St. Paul St. Baltimore, Md. 21218

Licensed by the State of Md.



BOLTON HILL *Dinner Theatre*

"Star Spangled Girl"

thru — July 27

"King of Hearts"

July 29 — Aug. 24

"The Impossible Years"

Aug. 26 — Sept. 21

Dinner — 7 P.M.
Performance — 8:30 P.M.
FREE PARKING
CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
11:30 AM - 2 AM

for Reservations
call 728-0800

Luncheon Served 11:30 AM-2 PM
Luncheon Fashion Show Every Thursday
Baltimores Only Professional Dinner Theatre

Who's Afraid of the Big Bad Wolf?

Afraid of the cold? The heat? The dark? Science has a word for you.

Do you fear dirt or nudity?

All the scientific words that describe your fears end in phobia. And most of us have at least one.

What's your phobia?

According to the Health Insurance Institute, many people have phobias without even realizing it—or being able to spell it.

Fear of the cold, for example, would be cheimophobia; fear of heat, thermophobia; of dirt, rypophobia; of darkness, achluophobia; of nudity, gymnotophobia.

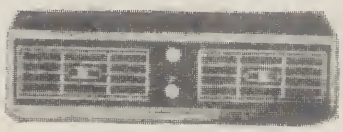
Here is a list of phobias prepared by the Institute that most laymen have probably never heard before:

Agoraphobia—fear of open spaces.
Algophobia or **odynephobia**—of pain.
Arachnephobia—of spiders.
Dipsophobia—of drinking.
Electrophobia—of electricity.
Ereuthophobia—of blushing.
Gamophobia—of marriage.
Graphophobia—of writing.
Hematophobia—of blood.
Ideaphobia—of thought.
Ochlophobia—of crowds.
Oikophobia or **ecophobia**—of home.
Phobophobia—of developing phobias.
Taphophobia—of being buried alive.
Siderodromophobia—of railway trains.
Sitophobia—of eating.
Xenophobia—of strangers.
Zoophobia—of animals.

JOIN OUR TAPE CLUB
FREE! FREE!
One tape Free with every 10 tapes you buy at our everyday low prices. **25% DISCOUNT** on all tapes, by such artists as: **Beatles, Glen Campbell, Cream, Frank Sinatra, Al Martino, Dean Martin.**

20TH CENTURY
AUTO RADIO & TV
912-922 CATHEDRAL ST. (at Eager)
BALTIMORE, MD. 21201
Phone 539-0662

20TH CENTURY
DRIVE-IN—FAST SERVICE



STEREO
TAPE PLAYER
for CAR, BOAT or HOME



AUTO AIR CONDITIONERS
SALES and SERVICES

Blue Shield's Future Role in Title 19

As experience mounts under the Title 19 federal-state matching programs for the medically indigent, the advantages of offering such programs on an underwritten basis are becoming increasingly apparent.

Of the 38 state Title 19 programs now in operation, 16 are administered by Blue Shield and Blue Cross. In 14 other states, Blue Shield and Blue Cross have either submitted proposals or are in the process of drafting proposals for a fiscal agent's role.

As of December 31, 1968, Blue Shield Plans served more than 3 million persons under Title 19.

While carrier-administered programs have fared better than programs administered by a single state agency, an underwritten program would make maximum use of those private carriers which have demonstrated their proficiency in underwriting and servicing a broad health care program for a large segment of the population.

Title 19 programs, administered by a state agency, tend to isolate the recipient from the health care mainstream. Furthermore, in almost all instances, single state agencies administering these programs have demonstrated inability to properly and expeditiously handle medical claims administration, budget projections, provider relations, utilization review, and quality assurance programs.

Under the underwritten programs, group contracts for eligible recipients could be handled by a separate state agency outside the welfare department. In the case of a cash grant recipient, this agency would pay 100% of the cost of the individual policy. Other subsidy levels would be established according to defined income limits.

Thus, through an underwritten program the Title 19 recipient would become a full-fledged member of the health-care-consuming public, enjoying the same type of recognition and security that current Blue Shield members now have.

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.

Miss Gladys Deeds
Manager

213 West Saratoga St. 727-7011

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

A & F Nurses Registry



LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

Registered & Licensed

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.
Baltimore, Md. 21218

BElmont 5-7135
If no answer call: HOpkins 7-6746

COLOSTOMY
ILEOSTOMY

Appliances and Disposable Bags

CALL
FIELDS PHARMACY
IN PIKESVILLE

for convalescent supplies and service

FOR RAPID DELIVERY **486-3300**

CLASSIFIED ADVERTISING

Effective May 1, 1963

$1.50 per line per insertion

Count seven average words to each line. Add one line if box number is desired.

Members of the Medical and Chirurgical Faculty shall be entitled to one complimentary insertion in any twelve-month period. Widows of members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment.

MARYLAND STATE MEDICAL JOURNAL
1211 Cathedral St., Baltimore, Md. 21201

Did You Know?

. . . that the dish we call "soup" had its beginnings in a tasty medieval snack called a "sop"? A "sop" consisted of bread chunks dipped in the broth of meat stews.

. . . that nearly 5 pounds of butter and about 15.2 quarts of ice cream were sold per person in the United States in 1967?

. . . that 34 percent of Americans go out for breakfast at least once a month; 63 percent enjoy a restaurant lunch at least monthly; and 59 percent have dinner in a restaurant once a month?

. . . that cow's milk is now available in tablet form? The tablets contain cow's milk that has been obtained through a process that removes the water and fat.

. . . that a study is currently underway to determine the effects of "the Pill" on body digestion and retention of nutrients, lactation and bone changes? The study is being conducted with rats.

. . . that Julius Caesar so loved Swiss cheese that he imported the delicacy for special banquets in ancient Rome?

. . . that houseflies are more susceptible to insect-killing sprays in the late afternoon than in the late morning?

. . . that the first food law of England was the Assize of Bread of 1203, dealing with false weights, and that offenders were driven through the streets with loaves of bread tied around their necks?

Classified Advertising

POSITIONS AVAILABLE

INTERNISTS—(General Medicine) for a 765-bed GM&S hospital and 550-bed Domiciliary; affiliated with George Washington Univ.; low-cost housing and excellent receational facilities available; within easy driving distance of Washington, D.C. and Baltimore, Md. An equal opportunity employer. Apply: Chief of Staff, VA Center, Martinsburg, West Virginia 25401.

PARTNERSHIP, GP—Modern two-doctor office building; well-equipped. Good country; congenial people. Baltimore-Washington area. Salary or percentage first year. Retiring in 2-3 years. Open staff hospitals available. Adequate time off. Details appreciated in reply. Write: Box #16, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

PHYSICIAN WANTED, PEDIATRICS SUBSPECIALTY—in Maryland suburbs adjoining Washington, D.C.; male or female; 5-day work week; good salary. Write: Box #15, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

EMERGENCY ROOM PHYSICIANS—Membership in Group Practice. Guaranteed minimum income $30,000. Include complete curriculum vitae in reply. Address to Haluk Boneval, MD, Chief, Emergency Room Service, Prince George's General Hospital, Cheverly, Md. 20785. Telephone: 301-341-3041.

FOR SALE

PHYSICIAN'S HOME & OFFICE—Two buildings of stone construction with slate roofs. Each building individually maintained with central heating and a/c. Two bedroom home. Office has large waiting room, 2 exam-consultation rooms, 2 bathrooms. Buildings connected by a breezeway and porch, enclosure—could be converted for other uses. Structures occupy one acre, center of a block on Liberty Rd, near Beltway Exit 18. Call: 653-6565 anytime.

MEDICAL EQUIPMENT—Diathermies, ultra violet, filing cabinet, desk and chair, operating table, scales, floor magnifying lamp, instruments, other. Owner selling. Call: 1-725-8135 eves.

HOME/OFFICE COMBINATION AND PRACTICE—Well-established practice for internist or general practitioner. Office suite on ground level consists of 5 large rooms, fully air-conditioned. Main floor has 4 large rooms, plus powder room, kitchen and laundry room. Six bedrooms, 2 full bathrooms on second floor. Third floor has 2 spacious bedrooms and powder room. Excellent condition. Reply: Box #14, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

COMPLETE CONTENTS OF ORTHOPAEDIST OFFICE—2 desks and other furniture, physical therapy equipment, instruments, file cabinets, treatment tables, etc. Contact: Philip O. Pelland, MD, 5610 54th Ave., East Riverdale, Md., or phone: 298-7294.

MEDICAL EQUIPMENT—Raytheon microtherm machine, examining table, and treatment table, all in good condition, very reasonably priced. Delivery can be arranged. Call: JU 5-2996 between 9 and 4:30, Mon. thru Fri. Silver Spring, Md.

Advertisers in This Issue

Abbey Rents 130
A & F Nurses Registry 135
Aids for Hearing, Inc. 134
Al-Lin Ambulance Service 37
Arundel Federal Savings & Loan Assoc. 40
Baltimore Nurses Exchange, Alice Weber 126
Baltimore Oxygen Supply Co., Inc. 129
Belvedere Hotel 132
Bolton Hill Dinner Theatre 133
Brentwood Inn 96
Bristol Laboratories 25
Broadview Restaurant 95
Burroughs Wellcome & Co., Inc. 24
Campbell Soup Company 61
Capital Savings & Loan Association 129
Oscar Caplan & Sons 8
Chernock Moving & Storage Co. 129
Club Venus 95
Cobb-Woods Services 133
Cork 'n Bottle Restaurant 95
Dobbs House 95
Doctors Supply Company 134
Dulaney Towson Nurs. & Conv. Home 92
Eastern Overall Div., Rentex Services Corp. ..2nd Cover
Eastern Research Laboratories, Inc. .....3rd Cover
Eleven East Chase St. Corp. 40
Embassy Dairy 40
Evangelical Press 45
Fedder's Medical Services 8
Federated Business Services, Inc. 126
Fields Pharmacy 135
Forty West Volkswagen 132
Franklin Uniform Co. 91
Geigy Pharmaceuticals 32–34, 41, 120–121
Glenbrook Laboratories 44
Greenberry Woods 130
Hecht Co. Northwood Rooftop Restaurant 95
High Fidelity House 96
Highland Hospital 20
Hood Convalescent Home 131
House in the Pines Nursing Homes 86
Hynson, Westcott & Dunning, Inc. 1
Key Circle Hospice Nurs. Home 132
Jobst Service Centers 17
Lederle Laboratories 2, 14, 20, 45, 96, 99, 116
Eli Lilly & Co. 4
Maryland Hospital Services, Inc. 7
Maico Hearing Aids, Inc. 40
Maria's 300 Restaurant 95
Maryland Volkswagen 20
McNeil Laboratories, Inc. 100
Medical Personnel Pool 116
Metropolitan Washington Blood Banks, Inc. 14
Michaelson Motors, Inc. 126
Miller Brothers Restaurant 95
Milton Inn 95
Monarch Lincoln Mercury 96
Murray-Baumgartner Surg. Instr. Co., Inc. 11
National Drug Co. 15–16, 110
Palmer House Restaurant 95
Parke, Davis & Co. 64
Chas. Pfizer & Co., Inc., Pfizer Laboratories Division, Bonine 66–67
Pleasant Manor Nurs. & Conv. Home 45
T. Rowe Price Growth Stock Fund, Inc. 45
Professional Management Co. 11
Professional Systems & Services 46
Geo. Radebaugh & Sons 131
Read's Drug Stores 92
Resinol Chemical Co. 86
R & H Motors, Inc. 104
A. H. Robins Co. 12, 26–31, 38–39
Roche Laboratories ..21–23, 42–43, 128–129, 4th Cover
Wm. H. Rorer, Inc. 19
Sandoz Pharmaceuticals 97
Manuel Schwartz 104
G. D. Searle & Co. 62–63
Skill Surgical Instrument Co., Inc. 118
Special Diet Shop 132
Sterling Lighting Co. 129
Strutt & Poole, Inc. 106
Mano Swartz—Furs 8
Therapeutic Appliances, Inc. 92
Tijuana Tacos 95
Town & Country Motors 132
Towson Valley Motors 14
Twentieth Century Auto Radio & TV 133
Ventnor Marine Service 124
D. Stuart Webb Advertising Services, Inc. 118
Westview Lounge & Supper Club 95
White Rice Inn 95
Winthrop Laboratories 98
Wyeth Laboratories 113–114, 119
Zimmerman's Shoes 8

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number. the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.



after surgery...

To restore tissue depletion of Vitamin B Complex and ascorbic acid induced by the physiological stress of surgery, illness or injury—Increases the recuperative power of convalescence.

beta massive capsules

B COMPLEX WITH VITAMIN C



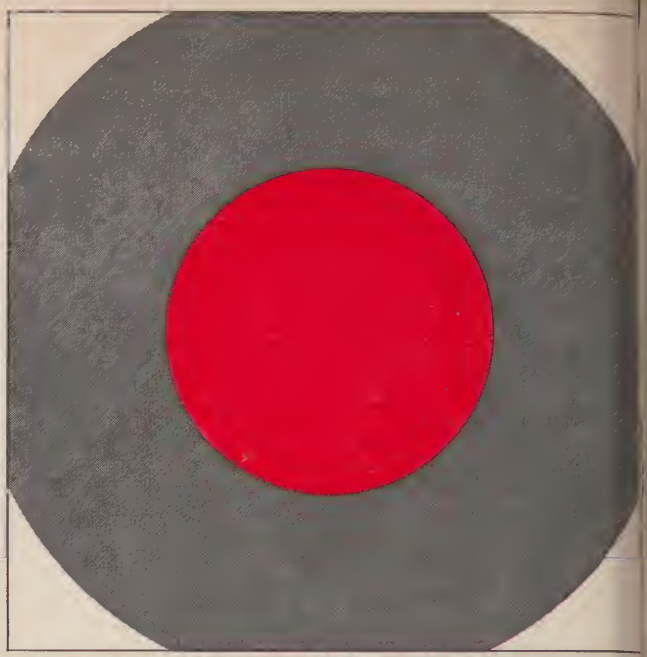
Thiamine HCl	B_1	10 mg.
Riboflavin	B_2	10 mg.
Pyridoxine HCl	B_6	5 mg.
Cyanocobalamin	B_{12}	4 mcg.
Ascorbic Acid	C	150 mg.
Calcium Pantothenate		20 mg.
Niacinamide		50 mg.

EASTERN RESEARCH LABORATORIES, INC.

302 S. CENTRAL AVE. BALTIMORE, MARYLAND 21202



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)

5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

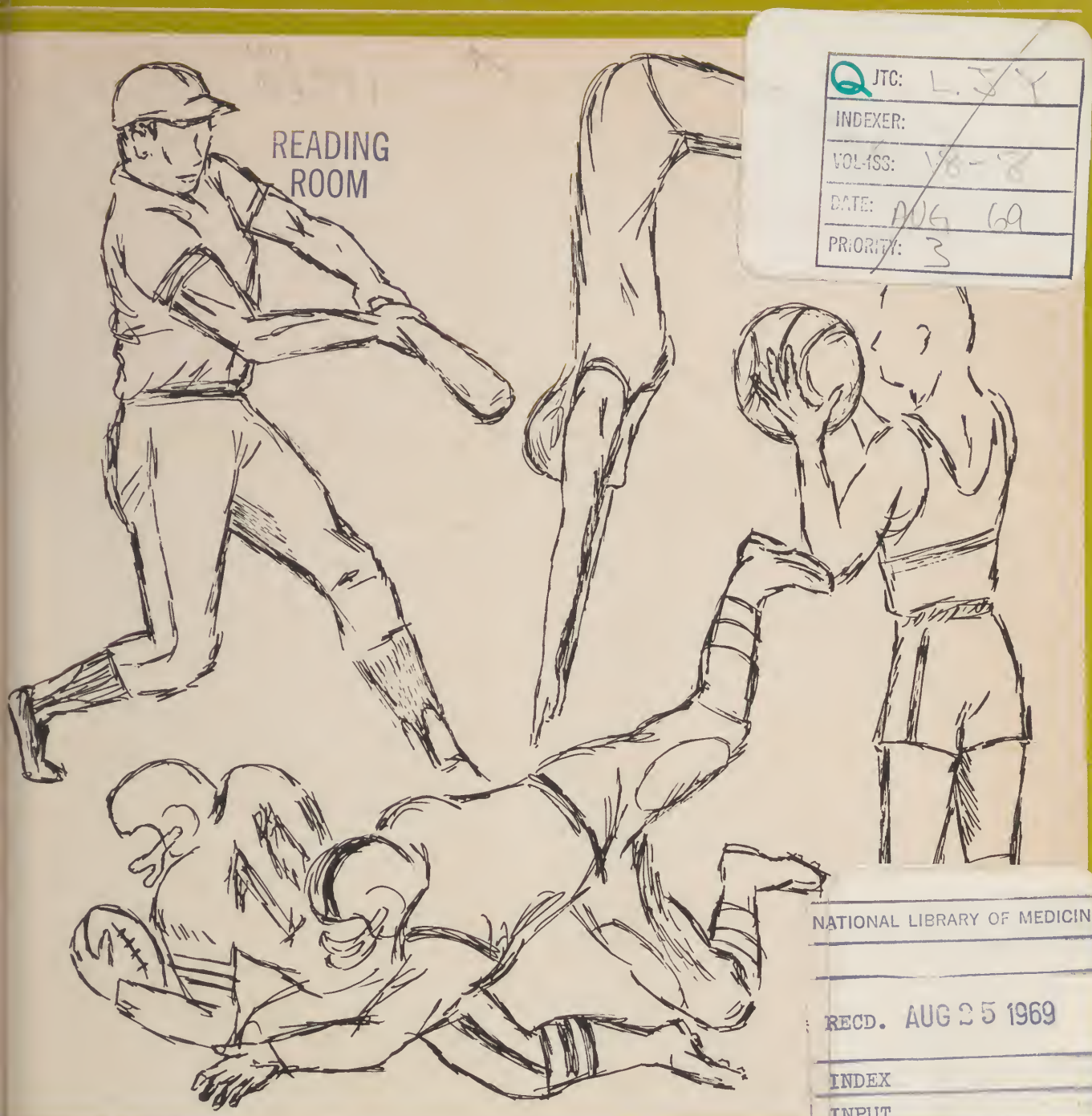
Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.



JTC: L.3.Y
INDEXER:
VOL-ISS: V18-8
DATE: AUG 69
PRIORITY: 3

NATIONAL LIBRARY OF MEDICINE
RECD. AUG 25 1969
INDEX
INPUT

Maryland State Medical Journal

FICIAL PUBLICATION OF THE MEDICAL AND CHIRURGICAL FACULTY OF THE STATE OF MARYLAND

VOLUME 18, NUMBER 8
AUGUST 1969

group therapy . . .



. . . gives individuals a chance to express their needs and problems. Taylor Manor Hospital helps find solutions for these individuals. With a small group, extensive facilities, and a specially trained staff, it is possible to rehabilitate with concentrated professional individual attention and the use of any or all psychiatric measures.

Taylor Manor Hospital is a licensed private psychiatric facility. The beautiful new psychiatric Center has increased the capacity to 151 beds.

There are treatment programs for alcoholism, drug addiction, and all types of emotional and mental aberrations in adults and adolescents over 12 years of age.

Most insurance plans, including Blue Cross, will cover part of the hospital expense.

Taylor Manor Hospital



For information and rates,
call or write:
Admitting Office
Taylor Manor Hospital
Ellicott City, Maryland 21043
301-465-3322

Taylor Manor Hospital

Fully accredited by the Joint Commissions on Accreditation of Hospitals

Lutrexin®

HW&D BRAND OF LUTUTRIN

3000 UNIT TABLETS

N THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF
'REMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

■ LUTREXIN, the non-steroid "uterine elaxing factor" has been found to be useful y many clinicians in controlling abnormal terine activity.

■ Literature on indications and dosage available on request.

■ No side effects have been reported, even when massive doses (25 tablets per day) were administered.

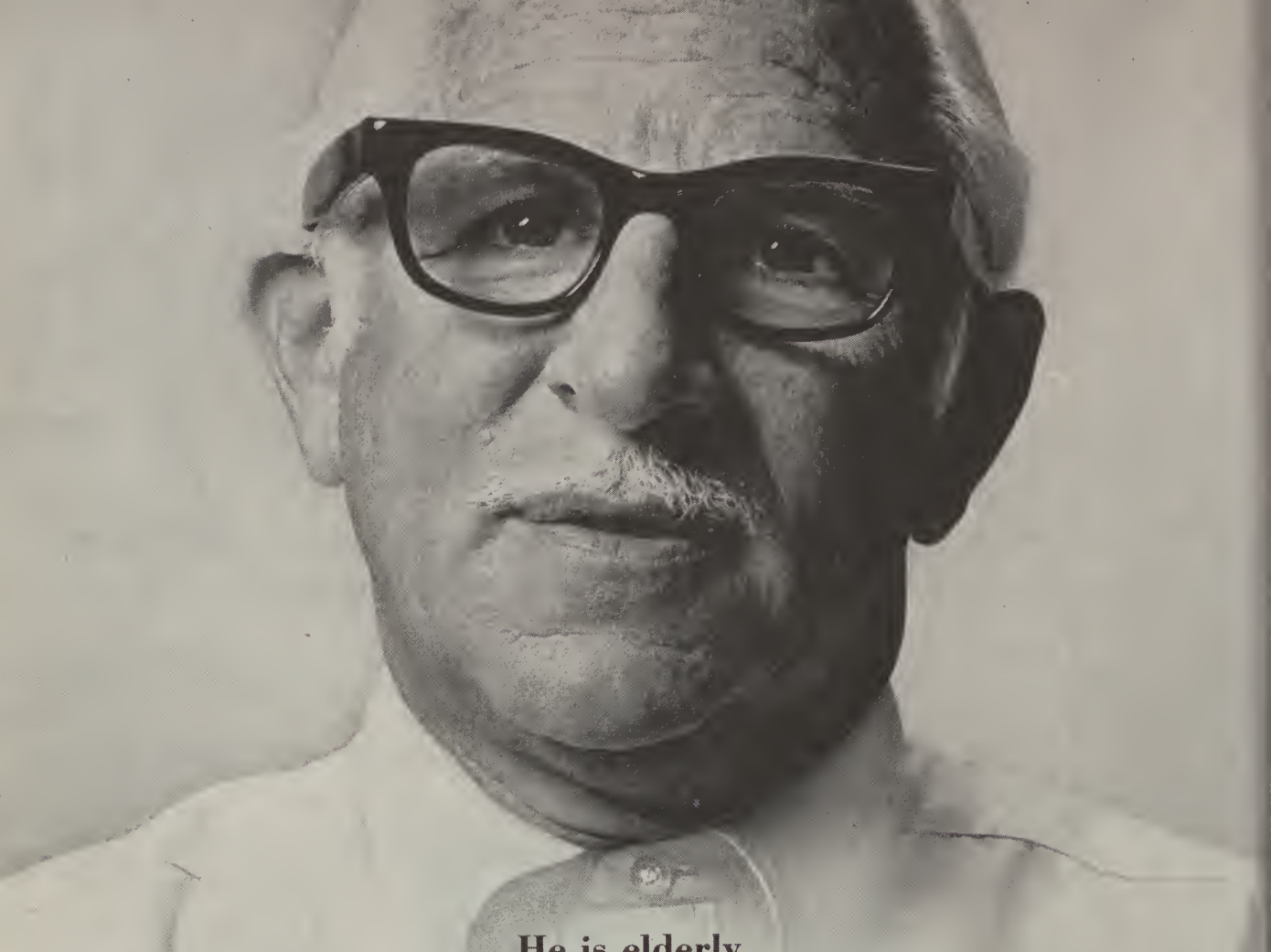
■ Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity; onycholysis and discoloration of the nails (rare). Kidney—rise in BUN, apparently dose related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium content drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

345-8

Maryland State Medical Journal

VOLUME 18 AUGUST 1969 NUMBER 8

CONTENTS:

Measurement of Physical Fitness, Edward N. Norris, EdD, RPT **70**

"Even a cursory survey of both professional and lay literature will evidence an overwhelming interest in 'physical fitness.' Indeed, the interest in and concern for fitness prompted the late President Eisenhower to create the Council on Youth Fitness now designated as the President's Council on Physical Fitness. Thus, in addition to the pleas of physical educators and physicians, even governmental agencies are urging both children and adults to achieve and maintain physical fitness."

Weight Control in Athletics, Herman C. Maganzini, MD, FACP **76**

"Weight control is a problem of substantial importance to all athletes and their coaches. In certain sports, such as wrestling, the attainment of a low weight can represent a disproportionate advantage. I hope to demonstrate that the proper weight loss or gain, to reach an optimum (rather than the minimum or maximum) is beneficial to the athlete in any sport including wrestling and football."

Skin Problems in Athletics, Harry M. Robinson, Jr., MD **81**

"It is interesting to note that the pamphlet published by the American Medical Association entitled, "Medical Evaluation of Candidates for School Sports" makes no mention of the cutaneous lesions that should disqualify a candidate for participation in athletic activities. It should be obvious that conditions such as, acne congoblata, furunculosis, impetigo contagiosa, monilial infections, plantar warts, swimming pool granulomas, mycotic infections, and contact dermatitis would disqualify a candidate for participation until the condition shows a satisfactory response to treatment. More adequate instruction should be given about the necessity for, and methods of, complete examination of the skin."

The Obese Child in Athletics, Milton S. Grossman, MD **83**

"Obesity can be determined in an individual by comparing weight to height. One of the most satisfactory charts for this purpose is the one based on Stuart's data. Stuart and his group in Boston were interested in anthropometry, the classification by body type—ectomorph, mesomorph, and endomorph—according to bone structure. This is an important concept to consider. There are numerous muscles in the body and mere weight does not reflect body mass, or the proportion of body mass that is fat."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant **86**

Rehabilitation Notes—Rehabilitation of Patients Suffering From Fracture of the Hip, Part II, John D. Hsu, MD **89**

Maryland State Department of Health—Highlights **91**

Heart Page—Arrhythmias in Myocardial Infarction, Chris Papadopoulos, MD **93**

Library Page—Business and Pleasure **97**

Tuberculosis—Course and Prognosis of Chronic Obstructive Lung Disease .. **99**

Baltimore City Health Department—New Sanitary Enforcement Program .. **101**

Maryland State Department of Mental Hygiene—On the Hospitalization of Drug Addicts **104**

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland.

Maryland. Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EDITORIAL ASSISTANT
Elizabeth Sinnott

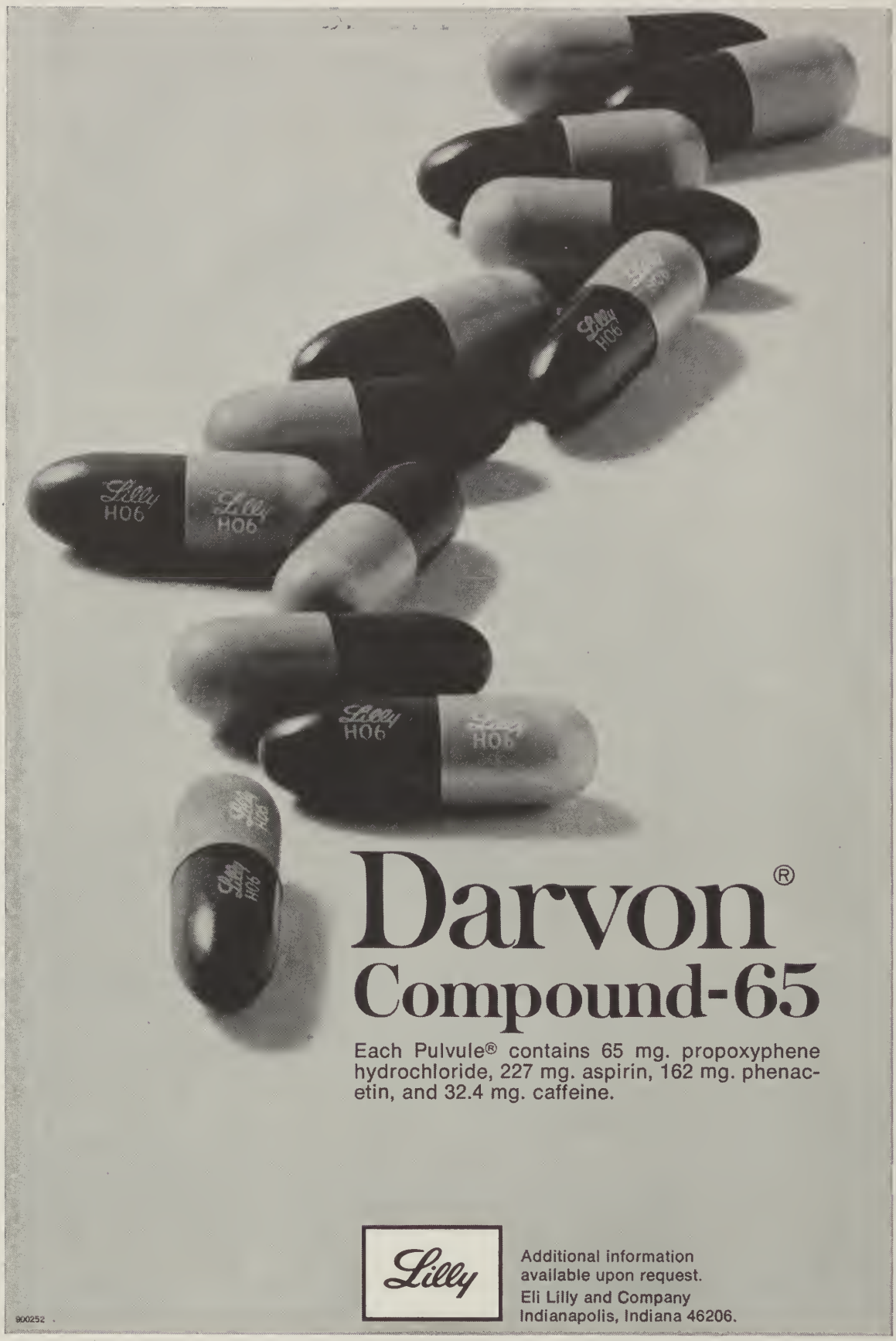
EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

Please return your Membership Directory card by August 30. If you have not received a card notify the Journal office at once, 539-0872.

Doctors Take Note **5**
Executive Secretary's Newsletter **9**
Recommendations for the use of Rubella Vaccine as approved by the Subcommittee on Immunization Practices **13**
Semiannual Meeting Activities Reservation Form **20**
Semiannual Meeting Program **21**
Golf Tournament Reservation Form **29**
The Month in Washington **31**
Cornerstone Laying Ceremony at Sheppard Pratt **44**
Medical News **45**
Semiannual Meeting Hotel Reservation Form **48**
MEDIC program for 1969-1970 **49**
1970 Annual Scientific Exhibits Form **56**
Letters to the Editor **69**
Library Accessions **98**
Book Reviews **102**
Better Emergency Care Sought for Highway Crash Victims **105**
Baltimore County Medical Association **109**
One Surgeon's Views of Fixed Fee Dilemma **115**
Advertising Index **119**
Classified Advertising **120**



Darvon®
Compound-65

Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.

Lilly

Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.

800252

Doctors take note...

AUGUST 21-23, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Clinical Gerontology: Shoreham Hotel, Washington, DC. Director: Ralph Goldman, MD, Professor of Medicine (Geriatrics), University of California. Co-director: Reubin Andres, MD, Associate Professor of Medicine, The Johns Hopkins University. Contact: Edward C. Rosenow, Jr., MD, Executive Director, The American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

SEPTEMBER 5-7, 1969
TIDEWATER HEART ASSOCIATION

10th Annual Cardiovascular Symposium: Williamsburg Lodge and Conference Center, Williamsburg, Virginia. For registration and further information, write to: Tenth Annual CV Symposium, Tidewater Heart Association, 523 Boush Street, Norfolk, Va. 23510.

SEPTEMBER 9-11, 1969
NORTHWESTERN UNIVERSITY MEDICAL SCHOOL/COOK COUNTY HOSPITAL/COOK COUNTY GRADUATE SCHOOL OF MEDICINE

6th Sumner L. Koch Postgraduate Symposium on Hand Surgery: Chicago. For further information, write: Registrar, Cook County Graduate School of Medicine, 707 South Wood St., Chicago, Ill. 60612.

SEPTEMBER 15-16, 1969
AMERICAN MEDICAL ASSOCIATION

29th Congress on Occupational Health: Stouffer's Riverfront Inn, St. Louis, Mo. There is no registration fee. For further information, contact: Council On Occupational Health, American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

SEPTEMBER 15-18, 1969
PENNSYLVANIA MEDICAL SOCIETY

1969 Scientific Session—"Clinical Therapeutics—1969": Host Farm Resort Motel, Lancaster, Pa. Contact: John H. Killough, MD, Chairman, Advisory Committee on Scientific Session, Pennsylvania Medical Society, Taylor Bypass & Erford Rd., Lemoyne, Pa. 17043.

SEPTEMBER 17-19, 1969
NEW YORK UNIVERSITY DEPARTMENT OF OB/GYN

Seminar—Conception Control: New York University Medical Center. Directors: Gordon W. Douglas, MD, Julia J. Tsuei, MD, Hans Lehfeldt, MD, and Livia Wan, MD. Application fee: $5. Contact: NYU Medical Center, OB/GYN, Division of Family Planning, 550 First Ave., New York, N.Y. 10016.

SEPTEMBER 17-19, 1969

ENVIRONMENTAL CONTROL ADMINISTRATION

Scientific Symposium—Biological Effects and Health Implications of Microwave Radiation: John Marshall Hotel, Richmond, Va. Contact: Chris A. Hansen, Commissioner, Environmental Control Administration, Bureau of Radiological Health, U. S. Dept. Health, Education, and Welfare, Rockville, Md. 20852.

SEPTEMBER 21-25, 1969

SPECIAL VIRUS CANCER PROGRAM OF THE NATIONAL CANCER INSTITUTE/LEUKEMIA SOCIETY OF AMERICA, INC.

4th International Symposium On Comparative Leukemia Research: Cherry Hill Inn, Cherry Hill, New Jersey. More than 80 papers will be presented by scientists and physicians from throughout the world to more than 500 attendees. Contact: Mr. Art Foley, Director of Public Education and Information, Leukemia Society of America, 211 E. 43rd St., New York, N.Y. 10017.

OCTOBER 6-10, 1969

COUNCIL ON MEDICAL EDUCATION OF THE AMERICAN MEDICAL ASSOCIATION

55th Clinical Congress: San Francisco. The Congress' program includes 15 carefully planned postgraduate courses and the Forum on Fundamental Surgical Problems, consisting of several hundred research-in-progress reports by young surgeons. Contact: American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

OCTOBER 11, 1969

AMERICAN COLLEGE OF PHYSICIANS

Regional Meeting (Maryland and DC): 8:30 AM, The Johns Hopkins Hospital, Turner Auditorium. All physicians, house staff and students are welcome.

MARK THIS DATE ON YOUR CALENDAR NOW

WEDNESDAY, NOVEMBER 5, 1969

SYMPOSIUM ON VIRAL DISEASES

Medical and Chirurgical Faculty Building

1211 Cathedral Street, Baltimore

A symposium co-sponsored by the Medical and Chirurgical Faculty, through its Committee on Postgraduate Education, Preventive Medicine, and Public Health, and the National Communicable Disease Center. Discussed will be such subjects as advances and horizons in virology, viral exanthems, hepatitis, respiratory viral diseases, laboratory diagnosis of viral diseases, antiviral agents, and rubella.

9:30 AM to 5:00 PM—Wednesday,

November 5, 1969

Registration fee, including lunch—$5.00

PLAN TO ATTEND

PLAN YOUR 1970 VACATION NOW

ORIENT TOUR

The Medical and Chirurgical Faculty is sponsoring a trip to the Orient, including 6 nights in Tokyo, 6 nights in Hong Kong and 2 nights in Honolulu. This all-inclusive trip is available at less than the regular round-trip air fare. Accommodations at deluxe hotels, full breakfast daily in the hotel, complete dinner nightly in a choice of restaurants, a modified sightseeing program, and all transportation are included. Leaves from Friendship Airport on May 1, 1970.

See the representative at the Hotel Hershey, September 4, 5, 6, during the Faculty's Semiannual Meeting, for full details and to make your reservation. A long to be remembered trip!

"Shall I order Maalox?"





"Yes. Patients respond well to it, and seem to take it more faithfully."

Works well · Doesn't constipate · Tastes good · Economical

Supplied: Maalox Suspension (12 fl. oz.). *Also available:* Maalox No. 1 Tablets (0.4 Gm.) : no sugar, low sodium content. Maalox No. 2 Tablets (0.8 Gm.) : double strength for double antacid action.

THE NUMBER ONE ANTACID

Maalox®

MAGNESIUM-ALUMINUM HYDROXIDE

ROHER

WILLIAM H. RORER, INC.
Fort Washington, Pa. 19034

We recommend **CAMP**

PENDULOUS ABDOMEN SUPPORTS



Specifically designed to balance the load of forward bulk in obese patients; affords relief of strain on muscles and ligaments of the back and feet in the ankle-joints, caused by weight-accented spinal curve, bowed head and rounded shoulders. These supports often improve circulation and digestive disturbances.

DONALD O. FEDDER, ORTHOTIST

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

BALTIMORE, MD.

You Gave Her a Ring— How 'Bout A Pin?



We have an extensive assortment—with and without diamonds or pearls—at the price you have in mind. Come see them.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday
and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.

ADVANCE FUR SALE!

Take your selection home for three days to inspect it and make your decision.

When you have confirmed your selection we will store your fur free of charge.

Your decision need not be final until you take your fur out of storage.

Your purchase MUST BE completely satisfactory

Maryland's Exclusive Representative for

Oleg Cassini
FURS



Mano Swartz

225 N. Howard St.
Baltimore, Md. 21201

LE 9-4900

executive secretary's newsletter

August, 1969

SELF-EMPLOYED PERSONS INCORPORATION CAUTION

A cautionary word is issued to all physicians who are contemplating incorporation under the Self-Employed Persons Act recently signed into law by the Governor.

Percentage arrangements of any sort are unethical and, under the regulations of the newly-in-force Commission on Medical Discipline, could be cause for revocation of license.

Physicians are reminded of this prohibition because attorneys who prepare such incorporation agreements are not always familiar with MEDICAL ETHICS, as opposed to the CANONS OF ETHICS of the Bar.

Copies of sample agreements for such incorporation may be obtained through the Faculty office.

NO SEMIANNUAL RESOLUTIONS

THERE ARE NO RESOLUTIONS FOR consideration at the Semiannual Meeting. Consequently, the date of the Reference Committee meeting has been cancelled.

NARCOTIC ADDICTION PROGRAM GUIDELINES

The Faculty's Mediation Committee has adopted strict regulations under which the various addiction programs in Maryland should operate.

Under these conditions, and only under these conditions can the Faculty consider such programs to be effective. A copy of the complete report and recommendations are being forwarded to the newly-created State Drug Abuse Authority for its consideration.

NEW PUBLICATION

In the hands of the printers is a new publication of the Faculty. Combining all previous individual publications into one, it will make a ready reference booklet for the busy physician and his aides.

It includes the various Codes of Cooperation subscribed to by the Faculty, as well as information on Laws, Rules and Regulations with which Physicians must Comply. In addition, it will also include appropriate reference materials in connection with other Faculty policies and positions.

NEW PUBLICATION (cont'd)

It will be available in the Fall and a copy will be mailed to all Faculty members.

DISPOSITION OF DRUG SAMPLES

Police throughout the State continue to bring to the attention of the Faculty that physicians (or their assistants) are indiscriminately disposing of drug samples in such a manner that they fall into the hands of unqualified persons.

Physicians are again reminded of their responsibility to dispose of unwanted drugs through proper channels, but in any event, through a mechanism whereby they do not fall into the hands of unauthorized personnel.

TRIP TO SPAIN

The Faculty-sponsored trip to Spain has now been scheduled for the period October 31-November 9. More details later.

APPOINTMENTS TO COMMISSION ON MEDICAL DISCIPLINE

For three-year terms:

John M. Dennis, M.D., Baltimore
Karl F. Mech, M.D., Baltimore
Eli M. Lippmann, M.D., Baltimore

for a two-year term:

Charles F. Bagley, III, M.D., Salisbury
Archie R. Cohen, M.D., Hagerstown
Uthman Ray, Jr., M.D., Baltimore

for a one-year term:

Elmer G. Linhardt, M.D., Annapolis
** Russell S. Fisher, M.D., Baltimore
** John F. Schaefer, M.D., Baltimore

** ex officio

John Sargeant
Executive Secretary

YOU CAN BE SURE

DOCTOR

YOUR SYSTEM ALSO NEEDS
PERIODIC CHECK-UPS . . .
IMPROVED ROUTINES AND
POSITIVE CONTROLS

℞

◆

All change is not progress—but
seldom is progress ever made
without change.

◆

OUR SERVICE OFFERS YOU

MAXIMUM CONTROL AND SAFETY
FROM BALANCING RECORDS AND
MINIMUM EFFORT ON YOUR PART

◆

FINANCIAL MANAGEMENT
CAN HELP YOU

◆

DIAL 752-5920

Professional Management Co.

914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN

STAIR-GLIDE®



INSTALLED IN TWO HOURS

For Information
and Complete Details

Call
FRED GEIWITZ
669-9300

Murray-Baumgartner

SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.

Phone: 669-9300 Baltimore, Md. 21216

Serving the Medical Profession for Almost Half a Century

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And free your secretary to be your secretary again.

professional systems and services *division of*

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3886



Recommendations for the use of Rubella Vaccine as approved by the Subcommittee on Immunization Practices* of the Medical and Chirurgical Faculty of Maryland

Introduction

Rubella Virus Vaccine, live is recommended for routine immunization of children between the ages of one year and puberty (12 years). An interval of at least four weeks should be observed between the dose of rubella vaccine and any other live virus vaccination, i.e., smallpox, polio, measles.

Contraindications

Pregnant women should not receive rubella virus vaccine. Patients who have severe underlying disease such as leukemia, or generalized malignancy and patients who are being treated with steroids, alkylating drugs, antimetabolites or radiation should not be vaccinated. Patients with severe febrile illness should not be vaccinated until they recover. Care should be exercised in vaccinating persons with known hypersensitivity to the species from which the tissue culture cells were derived, that is, monkey kidney, duck embryo, rabbit kidney, etc. (indicated on the labeling). Persons sensitive to neomycin should be excluded.

It is highly probable that the vaccine will be in short supply during the period immediately following its release for public distribution. This will necessitate the adoption of certain priorities as to whom the vaccine should first be given.

Recommendations

This Committee recommends that the vaccine be used as follows:

1. The vaccine acquired through a Federal Grant and administered by State and local health departments will be used primarily to immunize children of both sexes in the age group from kindergarten through the third grade including Head Start and Day Care children. It will be given in the schools.

2. Children from fourth grade through seventh (9-12 years) will not be included in the health department's program until the lower age group is covered, unless additional supplies of vaccine become available from Federal or local sources. Fifty percent of children by the time they are 7 are said to be immune to rubella from having had the disease. It is hoped that this group and especially the girls will be immunized and concentrated upon by private medicine. The waste of vaccine in vaccinating children already immune is avoidable only by making a pre-vaccination serology test for rubella antibodies. This is not recommended because it may be more expensive than giving vaccine to all girls in this age group.

3. When the supply of vaccine becomes more plentiful, rubella vaccination should be incorporated into the routine well-baby primary immunization schedule. In addition, immunization of remaining unprotected group of pre-school children can likewise be carried out.

4. For females who are above the age of 12 years and have passed puberty, the rubella vaccine should only be given with caution. It is possible that the greatest demand for rubella vaccination will come from girls and women in childbearing ages. Since the vaccine is absolutely contraindicated for women who are pregnant, every precaution must be taken to avoid the possible complications which might result from vaccinating a pregnant woman. The vaccination should be preceded by a blood test for rubella immunity. If the test shows a titer of 1-8 or greater, the woman is protected and there is no need for vaccination. If the test shows a titer of less than 1-8, the woman is susceptible to rubella. She may be vaccinated if it is certain that she is not pregnant and if she understands that it is imperative for her to avoid becoming pregnant for the following three months. Premarital examinations should include this procedure.

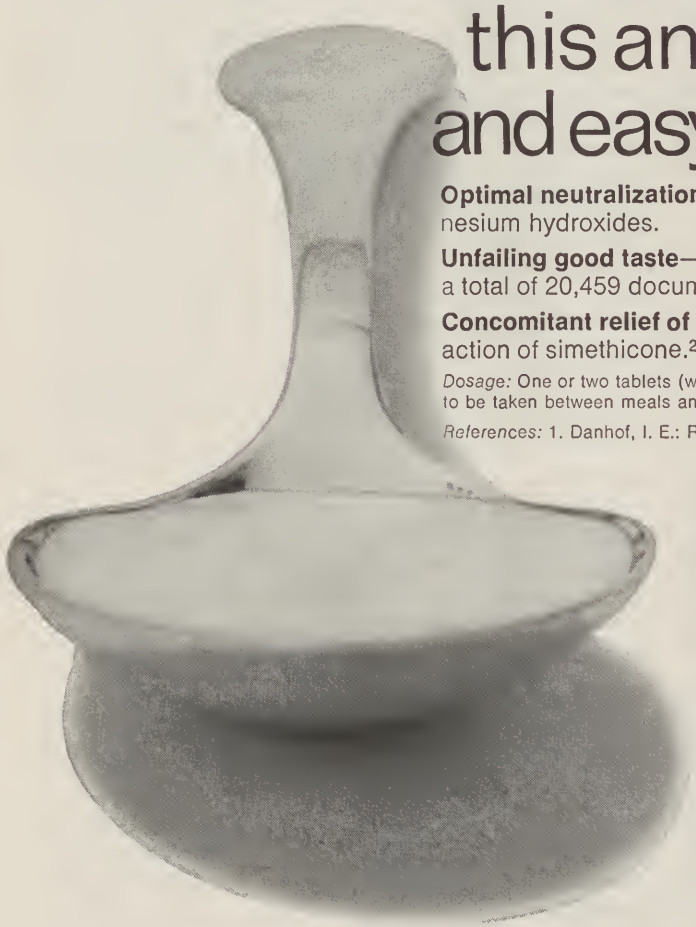
The Committee further recommends that although rubella vaccine is contraindicated for pregnant women every pregnant woman at her first prenatal examination should have a serologic test for rubella. Knowledge of immunity status may be valuable in the face of future exposure to the rubella virus (a case).

Warning: The medical profession is warned that the serologic test for rubella is a complex procedure which must be performed by well-trained competent technicians. In addition, a thorough knowledge of the immune response is essential for a proper interpretation of the test results. The HI test should not be attempted in a laboratory carrying out this test on an infrequent basis.

* Membership in the Subcommittee includes representatives of the State and Local Health Departments in addition to Medical and Chirurgical Faculty members.

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonomides.
Precautions/Adverse Reactions: The usual precautions for topical and systemic sulfonomides should be observed because of the possibility of absorption. Burning, increased local discomfort, skin rash, urticaria or other manifestations of sulfonomide toxicity are reasons to discontinue treatment.
Dosage: One applicatorful or one suppository intravaginally once or twice daily.
Supplied: Cream—Four-ounce tube with or without applicator. Suppositories—Box of 12 with applicator.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermat. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., and Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis and the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Today's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Gray, L. A., and Barnes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Salerno, L. J.; Ortiz, G., and Turkel, V.: Vaginitis: A Diagnostic and Therapeutic Approach, Scientific Exhibit, presented at the 115th Annual A.M.A. Convention, Chicago, Illinois, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvania Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (ominocrine hydrochloride 0.2%, sulfonilomide 15.0%, allontoin 2.0%)

AVC SUPPOSITORIES (ominocrine hydrochloride 0.014 Gm., sulfonilomide 1.05 Gm., allontoin 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69

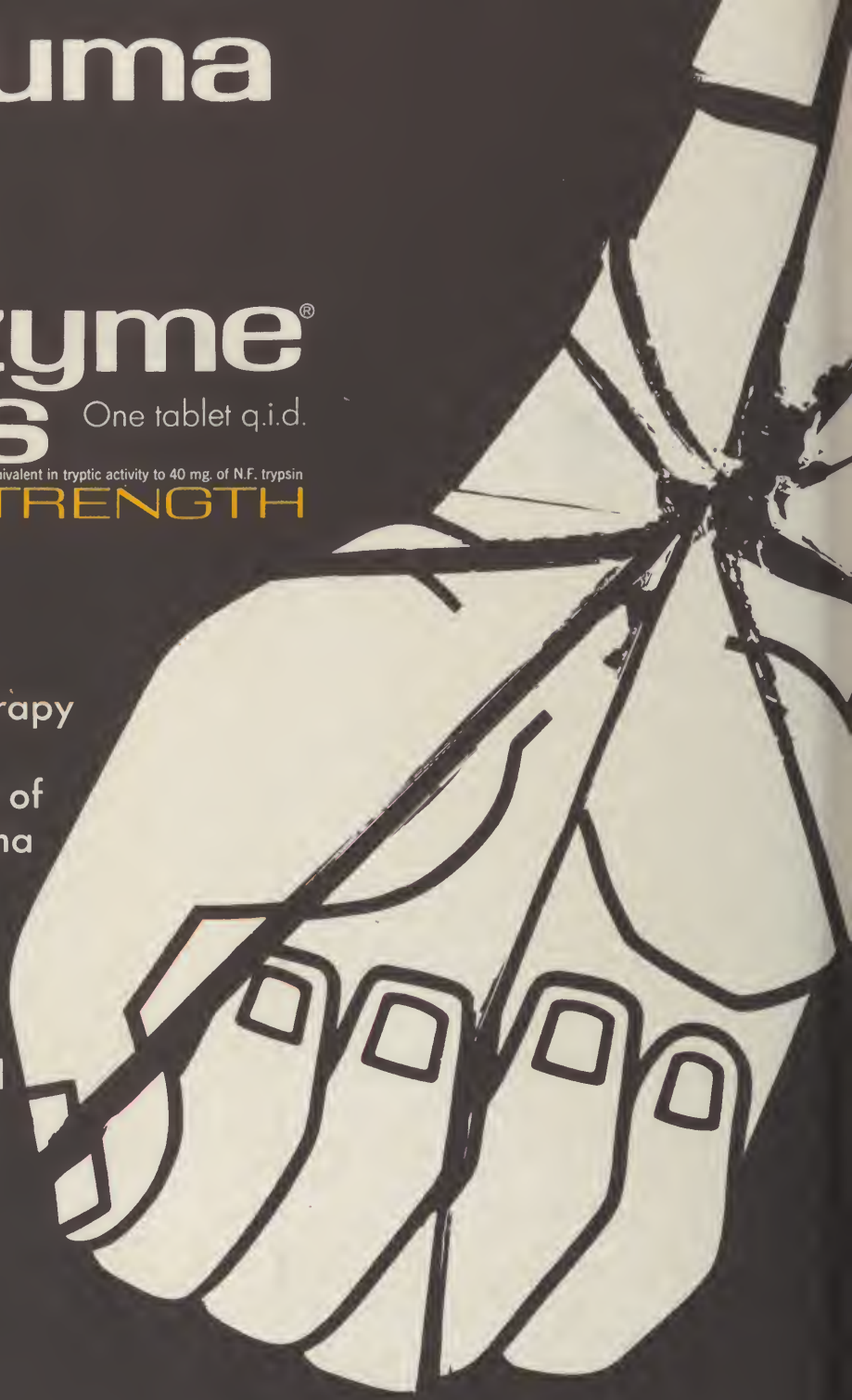
in trauma

new Orenzyme® Bitabs

One tablet q.i.d.

Trypsin: 100,000 N.F. Units, Chymotrypsin: 8,000 N.F. Units.; equivalent in tryptic activity to 40 mg. of N.F. trypsin

DOUBLE STRENGTH



Proteolytic enzyme therapy specifically indicated for the rapid resolution of inflammation and edema as adjunctive therapy in accidental and surgical trauma.

1 tablet q.i.d. provides recommended therapeutic dose at lower cost.



Description: ORENZYME BITABS offers the therapeutic effects of trypsin in an oral form as adjunctive therapy for the rapid resolution of inflammation and edema. ORENZYME BITABS is convenient to use, promotes patient cooperation and is ideally suited for maintenance therapy following parenteral trypsin.

Indications: When used as adjunctive therapy for the rapid resolution of inflammation and edema, good results have been obtained in:

- ☐ Accidental Trauma
- ☐ Postoperative Tissue Reactions.

Other conventional measures of treatment should be used as indicated. In infection, appropriate anti-infective therapy should be given.

Contraindications: ORENZYME BITABS should not be given to patients with a known sensitivity to trypsin or chymotrypsin.

Precautions: It should be used with caution in patients with abnormality of the blood clotting mechanism such as hemophilia, or with severe hepatic or renal disease. Safe use in pregnancy has not been established.

Adverse Reactions: Adverse reactions with ORENZYME have been reported infrequently. Reports include allergic manifestations (rash, urticaria, itching), gastrointestinal upset and increased speed of dissolution of animal-origin surgical sutures. There have been isolated reports of anaphylactic shock, albuminuria and hematuria. Increased tendency to bleed has also been reported but, in controlled studies, it has been seen with equal incidence in placebo-treated groups. (See Precautions.) It is recommended that if side effects occur medication be discontinued.

Dosage: One tablet q.i.d.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

TRADEMARK: BITABS U.S. PATENT NO. 3,004,893 4/69 0-821A

doctor's office



We can become that part of your office devoted to managing your funds for retirement and current tax deductions under the Self-Employed Individuals Tax Retirement Act (Keogh Bill). The Med-Chi Members Retirement Plan with Mercantile Safe Deposit and Trust Company offers the trustee great flexibility and an impressive record of performance. To arrange for a straight-talk session call the Med-Chi office at 539-0872 or ask for William Whitescarver in our Trustee's office at 539-1040.

MERCANTILE-SAFE DEPOSIT and TRUST COMPANY

"I'm sick of spinning"



When vertigo began, her life took a turn for the worse.
Either she spins and the room stands still,
or the other way around... and around and around.
Even when she lies down, the spinning
continues. Sometimes there's nausea and vomiting, too.
It's just one thing after another.

You can help stop the spin with

BONINE®

(MECLIZINE HCl)

Bonine protects most patients against vertigo and nausea up to 24 hours with a single dose. Pleasant-tasting Bonine tablets are chewable and can be taken anytime, anywhere, without water. In difficult cases, multiple daily doses may be necessary for maximum response.

Precautions: Although the incidence of drowsiness and atropine-like side effects such as dry mouth and blurring of vision is low, the physician should alert the patient to the need for due precautions when engaging in activities where alertness is mandatory. *Use in women of childbearing age:* In weighing potential benefits vs. risk in women of childbearing age, consider the fact that a review of available animal data reveals that meclizine exerts a teratogenic response in the rat. In one study a dose of 50 mg./kg./day (50 times the maximum recommended human dose) produced cleft palate in 2 of 87 fetuses when administered to the rat at critical times during the first 15 days of gestation. At doses of 125 mg./kg./day, meclizine will produce 100% incidence of cleft palate in the rat. At doses of 25 mg./kg./day, decreased calcification of the vertebrae and relative shortening of the limbs were also produced in the rat, but experts disagree as to whether this is a teratogenic response. While available clinical data are inconclusive, scientific experts are of the opinion that this drug may possess a potential for adverse effects on the human fetus. Consequently, consideration should be given to initial use of a nonphenothiazine agent that is not suspected of having a teratogenic potential. In any case, the dosage and duration of treatment should be kept to a minimum.
Supply: 25 mg. scored tablets.
More detailed professional information available on request.

Pfizer
LABORATORIES DIVISION
New York, N.Y. 10017

Reservation Form

MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND

SEMIANNUAL MEETING - HOTEL HERSHEY

PLEASE MAKE THE FOLLOWING RESERVATIONS (indicate number of persons attending each function and enclose check where required):

	Staying in Hotel Hershey	Not staying in Hotel Hershey
MONTE CARLO NIGHT Thursday, September 4	No charge	No charge
MMPAC LUNCHEON Friday, September 5	No charge	$4.50 per person*
GOLF TOURNAMENT Friday, September 5	**See separate reservation form for golf tournament on page 29 and return with this reservation form**	
TOUR OF HERSHEY MEDICAL CENTER Friday, September 5	No charge	No charge
COCKTAIL PARTY Friday, September 5	$4.00 per person*	$4.00 per person*
BANQUET Friday, September 5	No charge	$8.00 per person*
LUNCHEON Nursing Home Physicians Saturday, September 6	No charge	$4.50 per person*
TOUR AND LUNCHEON Amish Country Saturday, September 6	$2.50 per person for transportation No charge for luncheon	$7.00 per person* for transportation and luncheon
SURPRISE FUN NIGHT Dinner Saturday, September 6	No charge	$8.00 per person*

CHECK IS ENCLOSED FOR: $.....

.....
Name (please print)

.....
Address Zip

* Includes tip and tax.

PLEASE MAKE CHECK PAYABLE TO MEDICAL AND CHIRURGICAL FACULTY. **SEND TO:** CHARLES SAVARESE, MD, **1211 CATHEDRAL STREET,** BALTIMORE, MARYLAND 21201.

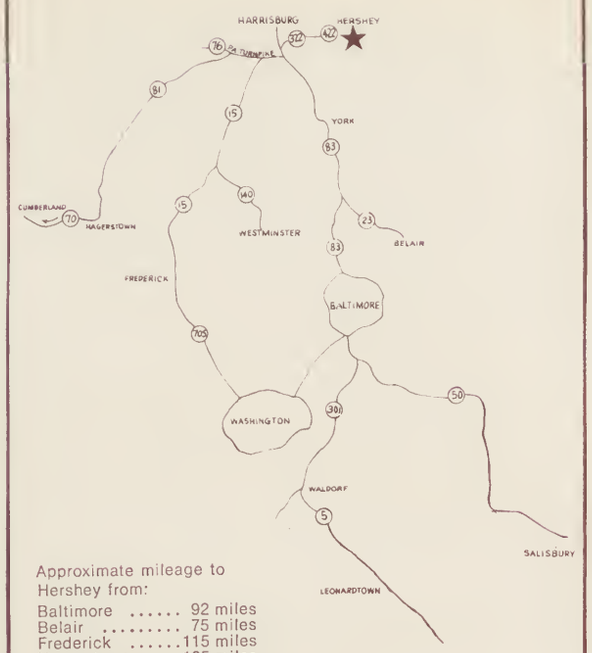
medical and chirurgical faculty of the state of maryland

official program
semiannual
meeting

HOTEL HERSHEY
hershey, pennsylvania

september 4, 5, 6, 1969

HOW TO REACH HERSHEY



Approximate mileage to Hershey from:

Baltimore	92 miles
Belair	75 miles
Frederick	115 miles
Hagerstown	125 miles
Leonardtown	170 miles
Salisbury	210 miles
Washington, D.C. (via Balto.)	130 miles
Westminster	95 miles

MEDICAL AND CHIRURGICAL FACULTY

OFFICERS

Russell S. Fisher, M.D., *President*
William A. Pillsbury, M.D., *Secretary*
Karl F. Mech, M.D., *Treasurer*
John Sargeant, *Executive Secretary*

COMMITTEE ON PROGRAM AND ARRANGEMENTS

DeWitt E. DeLawter, M.D., *Chairman*
Arlie R. Mansberger, Jr., M.D.
John B. De Hoff, M.D.
William L. Stewart, M.D.
Ernest B. Nuttall, D.D.S.
Genevieve Ritchie, *Executive Assistant*

Credit will be given by Academy of General Practice for attendance at scientific sessions.

REGISTRATION

Lower Lobby — Hotel Hershey

THURSDAY, SEPTEMBER 4
1:00 P.M. — 8:00 P.M.

FRIDAY, SEPTEMBER 5
8:30 A.M. — 4:30 P.M.

SATURDAY, SEPTEMBER 6
8:30 A.M. — 12 Noon

ALL MEMBERS AND GUESTS ARE REQUESTED TO REGISTER

NO REGISTRATION FEE

MONTE CARLO NIGHT

THURSDAY, SEPTEMBER 4
8:30 P.M.

Game Room — lower level
Hotel Hershey

PLAY THE GAMES
WIN THE PRIZES

See reservation form

HOUSE OF DELEGATES MEETING

FRIDAY, SEPTEMBER 5
9:00 A.M. — 11:00 A.M.

Mosaic Room — lower level
Hotel Hershey

ALL members of the Faculty are invited to attend the meetings of the House of Delegates.

◆ ◆ ◆

WOMAN'S AUXILIARY MEETING
9:30 A.M. — 10:45 A.M.

Plaza V — lower level
Hotel Hershey

Mrs. Wallace H. Sadowsky, *President*

Business meeting following which ALL Auxiliary members and guests are cordially invited to join the physicians for the 11:00 a.m. program.

>>>

FRIDAY

DRUG ABUSE: THE DANGERS AND RESPONSES

Harvey Grant Beck Memorial Lecture

11:00 A.M. — 12:30 P.M.

Castilian Room — upper level

Hotel Hershey

Louis J. Kolodner, M.D., Baltimore
Assistant Professor of Surgery,
The Johns Hopkins University School of Medicine;
Attending Surgeon, Sinai Hospital

The Honorable David Ross, Baltimore
Judge, Supreme Bench of Baltimore City

Steven V. Sklar, LL.B., Baltimore
Delegate, General Assembly of Maryland,
5th Legislative District, Baltimore City

Harvey Gollance, M.D., New York City
Associate Director, Beth Israel Medical Center;
Administrator, Methadone Maintenance Treatment Program

Has psychotherapy helped or failed? Is abstinence the only solution? Is maintenance the answer for some? Is a combination of methods the best approach? Should present drug laws be changed? What is the court approach? Will Maryland's new Drug Abuse Authority help? What do addicts, themselves, think? All these questions will try to be answered by the above leaders in their fields. An addict will be present to recount first hand experiences.

EVERYONE INVITED

GOLF TOURNAMENT

Hershey Country Club

Tee off **at noon with 8 minute starting intervals**

— 18 hole championship course —
— many and valuable prizes —
— special contests —

See reservation form

MMPAC LUNCHEON

(Maryland Medical Political Action Committee)

1:00 P.M.

Garden Terrace — main level

Hotel Hershey

WHAT'S THE ACTION and WHERE'S IT AT?

Chad P. Combs, Lemoyne, Pennsylvania
Assistant Director, Department of Field Service,
Public Affairs Division,
American Medical Association

No additional charge for persons registered in Hotel Hershey. ***See reservation form.***

SEPTEMBER 5

CONDUCTED TOUR OF

MILTON S. HERSHEY MEDICAL CENTER

of the

PENNSYLVANIA STATE UNIVERSITY

2:30 — 4:30 P.M.

A new concept in medical schools — unique to the Hershey School are departments of family and community medicine, humanities, and behavioral science.

See reservation form

TOUR OF TOWN OF HERSHEY

and

CHOCOLATE FACTORY

"ON YOUR OWN"

Factory open for tours **between 8:30 and 10:30 a.m.** and **between 11:30 a.m. and 3:15 p.m.** No charge.

COCKTAIL PARTY

6:30 — 7:30 P.M.

AROUND THE FOUNTAIN IN THE PATIO

Main level — Hotel Hershey

See reservation form

BANQUET

7:30 P.M.

Dining Room — main level

Hotel Hershey

SPECIAL ENTERTAINMENT

No additional charge for persons registered in Hotel Hershey. ***See reservation form.***

>>>

SATURDAY

MARYLAND CHAPTER, AMERICAN COLLEGE OF SURGEONS

8:30 A.M. — 12:30 P.M.

Mosaic Room — lower level

Hotel Hershey

Program Chairman
Robert J. Wilder, M.D., Section Chief,
Trauma Committee, American College of Surgeons

Chest Injuries
Elliott Michelson, M.D., Assistant Professor of Surgery
The Johns Hopkins University School of Medicine

Treatment of Burns
Thomas J. Krizek, M.D., Associate Professor of Surgery and Chief, Division of Plastic Surgery,
Yale University School of Medicine

The Battered Liver
Neil Novin, M.D., Chief, Department of Surgery,
South Baltimore General Hospital

Some Practical Aspects of the Treatment of Shock
R Adams Cowley, M.D., Chief, Division of Thoracic and Cardiovascular Surgery,
University of Maryland Hospital

Panel Discussion on All Aspects of Trauma
By all participants

Brief Business Meeting

◆ ◆ ◆

MARYLAND DIABETES ASSOCIATION

9:00 A.M. — 10:45 A.M.

Plaza V — lower level

Hotel Hershey

The Physiological Control of Diabetes
Francis D. Lukens, M.D., Chief of Staff,
Veterans Administration Hospital, Pittsburgh, Pennsylvania; Former Professor of Medicine and Director of the George S. Cox Medical Research Institute, University of Pennsylvania School of Medicine

◆ ◆ ◆

MARYLAND PSYCHIATRIC SOCIETY

9:30 A.M.

Oak Room — lower level

Hotel Hershey

Recognition of Brain Diseases in Patients Presenting Emotional Disturbances
Dietrich P. Blumer, M.D., Assistant Professor of Psychiatry, The Johns Hopkins University School of Medicine

FIRST ANNUAL GOLF TOURNAMENT
MEDICAL AND CHIRURGICAL FACULTY OF MARYLAND
FRIDAY, SEPTEMBER 5, 1969 - HERSHEY, PENNSYLVANIA

WHO:	Faculty members and their guests
WHERE:	Hershey Country Club—18 hole championship course
WHEN:	Friday, September 5, 1969
TIME:	Tee off at noon with 8 minute starting intervals
PRIZES:	Many and valuable—special contests
HANDICAP:	Bring your own—modified Calloway System for the duffer
WITH WHOM:	Fellow members—make up your own foursome if you desire
COST:	Green fees are $6.00—caddy fees are $3.00 single and $6.00 double——electric golf cart rental, $8.00
COMMITTEE:	Charles Savarese, MD, Chairman Frederick M. Johnson, MD Austin B. Rohrbaugh, MD

* * * * * * * * * * *

DETACH AND MAIL THIS ADVANCE REGISTRATION FORM **PROMPTLY**

FIRST ANNUAL GOLF TOURNAMENT
Friday, September 5, 1969, Hershey Country Club

PLEASE MAKE THE FOLLOWING RESERVATIONS FOR ME:

..... Assign me to a foursome. My preferred starting time is ..... p.m.

..... In **addition to my registration** fee, I am **including payment** for the following persons:

1. ..... Golf ($6.00) .....
   Name (please print) Cart ($8.00) .....

2. ..... Golf ($6.00) .....
   Name (please print) Cart ($8.00) .....

3. ..... Golf ($6.00) .....
   Name (please print) Cart ($8.00) .....

TOTAL $.....

(**caddy fees** will be payable at time of tournament)

.....
Name (please print)

.....
Address Zip

PLEASE MAKE CHECK PAYABLE TO MEDICAL AND CHIRURGICAL FACULTY AND **SEND TO** CHARLES SAVARESE, MD, **1211 CATHEDRAL STREET,** BALTIMORE, MARYLAND 21201.

Heart Transplants

and the Life Insurance Medical Research Fund

The Life Insurance Medical Research Fund is playing a significant role in research on heart transplantation, according to the Fund's Annual Report, issued recently, which outlines some of the 64 grants and fellowships totaling more than $1.5 million for the 1968-69 year.

The LIMRF, supported by more than 130 life insurance companies in the United States and Canada, presents the awards annually to aid medical research in the biological and life sciences. Since the establishment of the Fund in 1945, approximately 900 institutions and medical scientists have received more than $23 million.

Featured in this year's report is the research done by previous recipients in two of medicine's most discussed areas: heart transplantation and synthetic life. The report points out that many continuing research projects in these two areas have been undertaken in heart surgery, oxygen exchange, infections, red blood cells, genetic code, and structure of enzymes and proteins.

The report also discusses the accomplishments of eight medical scientists who completed their fellowships this past year, as well as eight of the 30 institutions awarded grants this year.

To obtain a copy of the report, write to: Institute of Life Insurance, 277 Park Ave., New York, N. Y. 10017.

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

PROFESSIONAL LEASING
Special low rates for our medical customers. Call or stop in.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL
5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

DO YOU NEED



If you are a doctor or dentist or supervise a staff in a hospital or nursing home, there are times when you have wished that help was a phone call away. Now it is. Call us night or day for the nursing or medical office employees you need. Our service is national, our employees are experienced, screened, insured and bonded.

MEDICAL PERSONNEL POOL
Washington—Phone 667-6345
Baltimore—Phone 685-5053

THE MONTH IN WASHINGTON

The Internal Revenue Service plans to audit the federal income tax returns of physicians and other health practitioners who have received more than $25,000 a year in medicare and medicaid payments.

Plans for the special audit were disclosed by IRS Commissioner Randolph W. Thrower at the first of a series of public hearings the Senate Finance Committee is holding in its investigation of the rising costs of the two government health care programs. He said the Department of Health, Education and Welfare had agreed to require intermediary insurance carriers to use physicians' social security numbers on reports of payments under the program in the future.

Finance Committee Chairman Russell B. Long (D., La.) estimated "possibly as many as 10,000" had been getting upwards of $25,000 a year under the programs. Thrower said the initial audits would be for 1967 and would be limited to those receiving more than $50,000.

Long said that the investigation of the committee's staff so far showed "widespread abuse, and fraud, as well as lax administration."

Robert M. Ball, social security administrator, reported his investigators had looked into more than 700 possible fraud cases under medicare. He said more than 300 of these cases were still in some stage of inquiry, and that 14 had been turned over to the Justice Department for prosecution.

"But these should not be taken as a reflection on the 200,000 doctors participating in medicare," Ball said. He added that a bigger problem than outright fraud were "cases that don't quite become fraud."

HEW Undersecretary John G. Veneman told the committee that the Nixon Administration wants congressional authority to stop medicare payments to doctors who overcharge, use inferior supplies, or engage in fraud.

"Under present medicare law, there is no authority for the program to deny reimbursement to a licensed practitioner, who has demonstrated a clear pattern of fraud, repeated overcharging of the program or the use of supplies which are inferior or harmful," Veneman said.

"We are recommending authority . . . to discontinue future reimbursement and to put all parties on notice to this effect where on the basis of clear evidence, a finding is made that this is justified by reason of such abuses."

Commenting on the hearings, **Dwight L. Wilbur, MD,** President of the American Medical Association, said that the vast majority of physicians serving medicaid patients are not overcharging for their services.

"Most physicians," Dr. Wilbur said, "are acting honorably and with utmost restraint. Fortunately, very few MD's participating in medicaid are guilty of overcharging and otherwise exploiting the program. Such exploitation by a minuscule minority was unavoidable. . . .

". . . The medical profession is making a great effort to identify and weed out dishonest doctors who betray their oath as professional men serving the public. We have been successful in this search, but a few physicians remain who still are not identified. We shall search them out and expose them, for the good of the entire profession."

Meantime, HEW issued a regulation limiting the fees paid by states to physicians, dentists, and other health practitioners under medicaid.

Under the regulation, a state's medicaid payment to a physician for a service shall be limited, with one exception, to the 75th percentile of the customary charge—the maximum customary fee of 75% of the physicians in the area.

If a state has been paying more than the 75th percentile of the customary charge, it must not exceed the medicare level, about the 83rd percentile. A medicaid official said that only two states may have to roll back their fees, but declined to name them.

After July 1, 1970, states may request permission to increase physicians' fees above the 75th percentile if two conditions are met:

1. The average percentage increase requested above the 75th percentile on January 1, 1969, may not exceed the percentage increase in the all-services component of the Consumer Price Index (adjusted to exclude the medical component) or in an alternate index designated by the Secretary of Health, Education, and Welfare.

2. Evidence must be clear that the providers and the states have cooperatively established effective utilization review and quality control systems.

The new fee regulation also requires states to revise their

medicaid plans to include descriptions and details of their payment structures. A state that wishes to revise its payment structure for practitioner's services or change the payments authorized under it may not do so until the proposed changes have been approved by the Secretary of Health, Education, and Welfare or his representative.

States that begin their medicaid programs after July 1, 1969, must arrange their payment structures so that fees do not exceed the 75th percentile of customary charges.

HEW estimated the regulation would result in a saving of $65 million in the first year.

Despite a strong protest by the American Hospital Association, HEW discontinued the overhead medicare-medicaid percentage allowance paid to hospitals, extended care facilities and other institutional providers. It was 2% for non-profit and 1½% for proprietary institutions. The action became effective July 1, 1969.

Another new medicaid regulation requires states to provide periodic health screening, diagnosis, and treatment for all eligible youths under 21 years of age, effective July 1, 1969.

HEW also established a new classification of institution—called intermediate care facility—eligible to receive federal contributions for the care of aged, blind, or disabled recipients; public assistance is covered in another regulation. This should reduce costs of medicaid by allowing states to relocate substantial numbers of welfare recipients who are now in skilled nursing homes in lower costs institutions, HEW said.

*** *** ***

Roger O. Egeberg, MD, who has been dean of the School of Medicine, University of Southern California since 1964, was selected to be the new Assistant Secretary of Health, Education, and Welfare for Health and Scientific Affairs after a five-month delay.

President Nixon nominated Dr. Egeberg after HEW secretary Robert H. Finch "reluctantly and regretfully" withdrew his unannounced, but widely-publicized, selection of John H. Knowles, MD, director of Massachusetts General Hospital, Boston. Finch said that "the protracted and distorted discussion" about the appointment during the five months the post had been vacant "resulted in a situation in which he (Knowles) would not be able to function effectively in this critical position."

The news media—press, radio and television—generally assigned the opposition to Dr. Knowles to conservative members of Congress, led by Senate Republican Leader Everett M.



Apply internally.

Take a relaxing break for Coca-Cola. Couple of times a day. Because Coke has the taste you never get tired of. It's always refreshing.

Dirksen, and to the AMA.

Throughout the public controversy before the appointment, the AMA confined its comment to a short statement that it had suggested several names to Finch for the post and that the Association "favored the appointment of someone who would represent the broadest scope of medicine and would not be too closely oriented to any one segment of medicine or the health field." Knowles was not one of the physicians on the AMA list.

A few days after the nomination of Dr. Egeberg, Dr. Dwight L. Wilbur said:

"During the last five months the American Medical Association has been identified repeatedly as a force opposing appointment of Dr. John H. Knowles as Assistant HEW Secretary for Health and Scientific Affairs.

"We held our silence during the last months of nation-wide publicity because we agreed with Secretary Finch to make our suggestions to him and then say no more. We did that. The Knowles protagonists obviously did just the opposite . . . .

"In a true sense, we never opposed Dr. Knowles. But we did not support him because we had alternative recommendations."

Those recommended by AMA for the position, Dr. Wilbur said, included:

Dr. W. Clarke Wescoe, former Chancellor of the University of Kansas, "who withdrew soon after because of personal reasons." **Dr. Richard S. Wilbur,** Palo Alto Clinic, Chairman of the Council of the California Medical Association, and former Chairman of the Board of California Blue Shield, "who happens to be my nephew, a fact which complicated the situation, but who AMA felt was a well-qualified man for this position. **Dr. John R. Hogness,** Dean of the University of Washington School of Medicine, "who serves in the AMA House of Delegates, at a high level in the Association of American Medical Colleges, and who has many other distinguished achievements."

The AMA commended the selection of Dr. Egeberg. In a telegram to Finch, Dr. Wilbur said:

"We look forward to a productive relationship with you and Dr. Egeberg in advancing the health care system for the benefit of all the American people. There are many complex factors involved that will call for the wholehearted dedication and contribution of all in the medical profession and in government. . . ."

"We believe Dr. Egeberg will be able to bring about the necessary close coordination between government and private sectors in the health care system. This is vital to constantly advance and expand the ability

HIGHLAND HOSPITAL

Asheville, North Carolina

Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, athletic activities and games, recreational aotivities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, *Coordinator of Admissions*

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—254-3201

to provide quality health care for all Americans."

Dr. Egeberg, 65, is a large, bluff man of Norwegian stock who revealed a sense of humor at his first news conference. He is a member of the AMA and a Diplomate of the American Board of Internal Medicine. Generally considered a moderate liberal on health matters, he served on several advisory commissions during the Kennedy and Johnson Administration, and on the state level in California. One of his major interests has been health care of the poor and he arranged for the USC medical school to be the medical consultant for the neighborhood health center in the Watts district of Los Angeles.

At his first news conference in HEW, he classified delivery of health care as almost the department's number one problem. He said medicare now is "rather well established" in solving a problem. But medicaid, he said, "has run afoul of a number of things, and I don't know that one can blame any one person or any group for this."

A member of the army medical corps in World War II, he was personal physician and aide-de-camp to General of the Army Douglas MacArthur, 1944-45.

Average Prescription Drug Costs $3.43

Surveys reveal that the average retail price of life-saving, health-giving prescription drugs is only $3.43, including all the costs and earnings of the manufacturer, wholesaler, and pharmacist.

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#800—100% Nylon Taffeta **$5.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only

Sizes 34 to 46





MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab. **$9.99**

Sizes 28-40

- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

#604—Short Sleeves 100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46



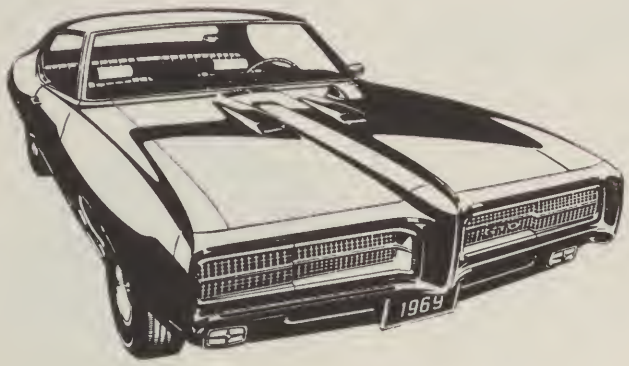
OTHER STORES IN →

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639

Kelly Pontiac's Annual Model End Sale!



No Gimmicks! Just honest, substantial savings on every 1969 Pontiac and Tempest in stock.

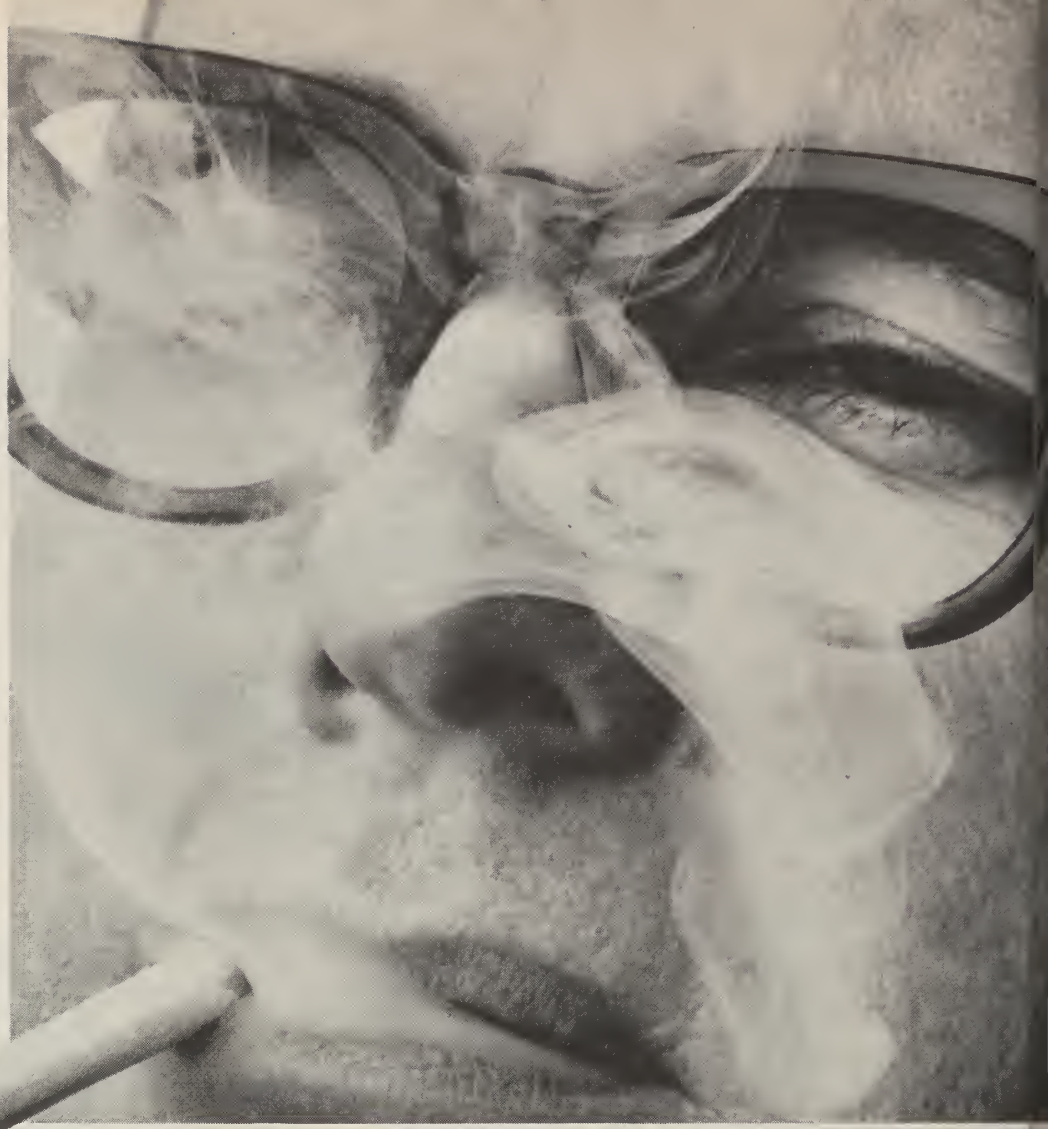
Choose from an outstanding selection!

SUPER-SAVINGS ON 1968 CARRY-OVERS, SCHOOL CARS, EXECUTIVE'S CARS AND DEMONSTRATORS!

KELLY PONTIAC

MARYLAND'S OLDEST AND LARGEST PONTIAC DEALER

5801 BELAIR ROAD AT WHITE AVENUE



Clues to PVD

The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt —bottles of 50.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort... and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering Librium (chlordiazepoxide hydrochloride) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards. As with all anticholinergic drugs, an inhibiting effect on lactation may occur.

PRECAUTIONS: In elderly and debilitated, limit dosage to smallest effective amount to preclude development of ataxia, oversedation or confusion (not more than two capsules per day initially; increase gradually as needed and ter-

or here.



ited). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

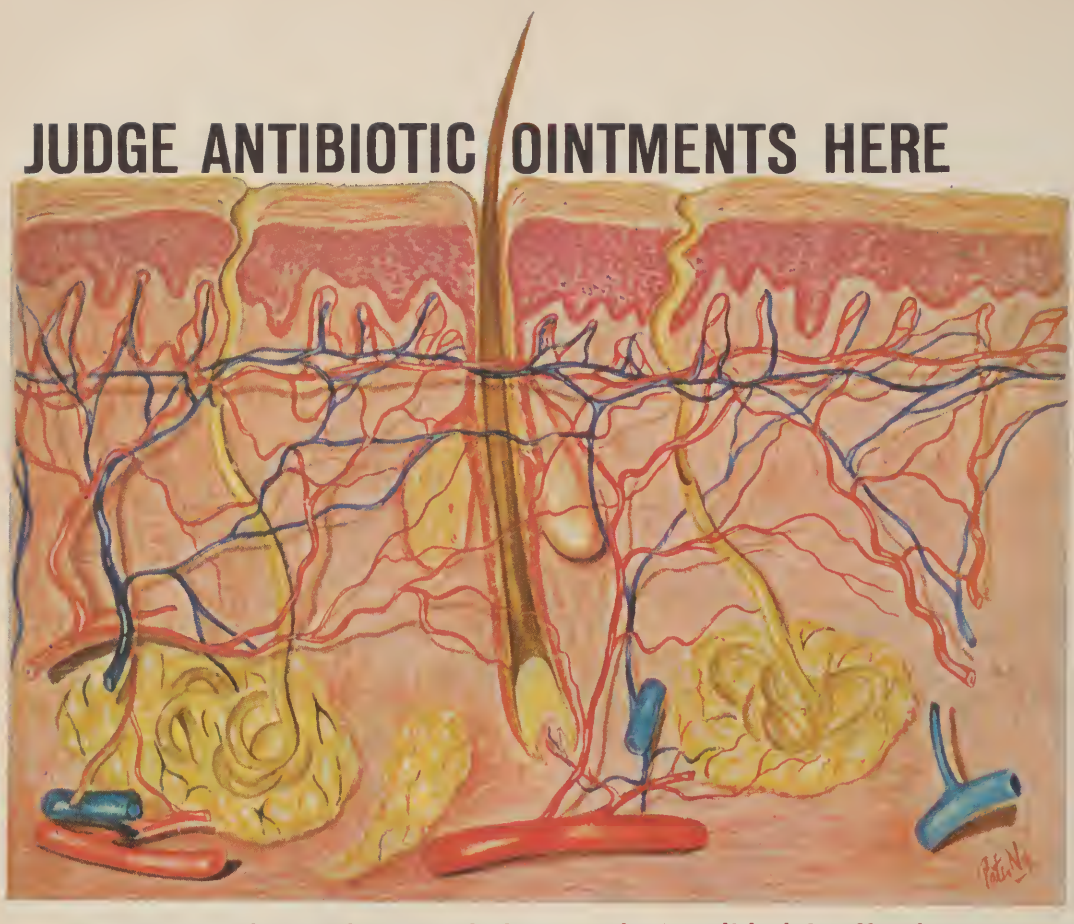
ADVERSE REACTIONS: No side effects or manifestations not seen with either compound alone have been reported with Librax. When chlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

We Repair and make Lamps
"Lamps make the home Beautiful"

LE 9-0222

403 N. Charles Street
Baltimore, Md. 21201

A & F Nurses Registry



Registered & Licensed

LICENSED & BONDED

- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

For Private Home
Hospitals
Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.

BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545



BOLTON HILL *Dinner Theatre*

"King of Hearts"
thru Aug. 24

"The Impossible Years"
Aug. 26 — Sept. 21

Dinner — 7 P.M.
Performance — 8:30 P.M.
FREE PARKING
CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
5 PM — 2 AM

for Reservations
call 728-0800

Baltimores Only Professional Dinner Theatre

JOIN OUR TAPE CLUB

FREE! FREE!

One tape Free with every 10 tapes you buy at our everyday low prices. **25% DISCOUNT** on all tapes, by such artists as: **Beatles, Glen Campbell, Cream, Frank Sinatra, Al Martino, Dean Martin.**

20TH CENTURY AUTO RADIO & TV

912-922 CATHEDRAL ST. (at Eager)
BALTIMORE, MD. 21201
Phone 539-0662

20TH CENTURY

DRIVE-IN—FAST SERVICE

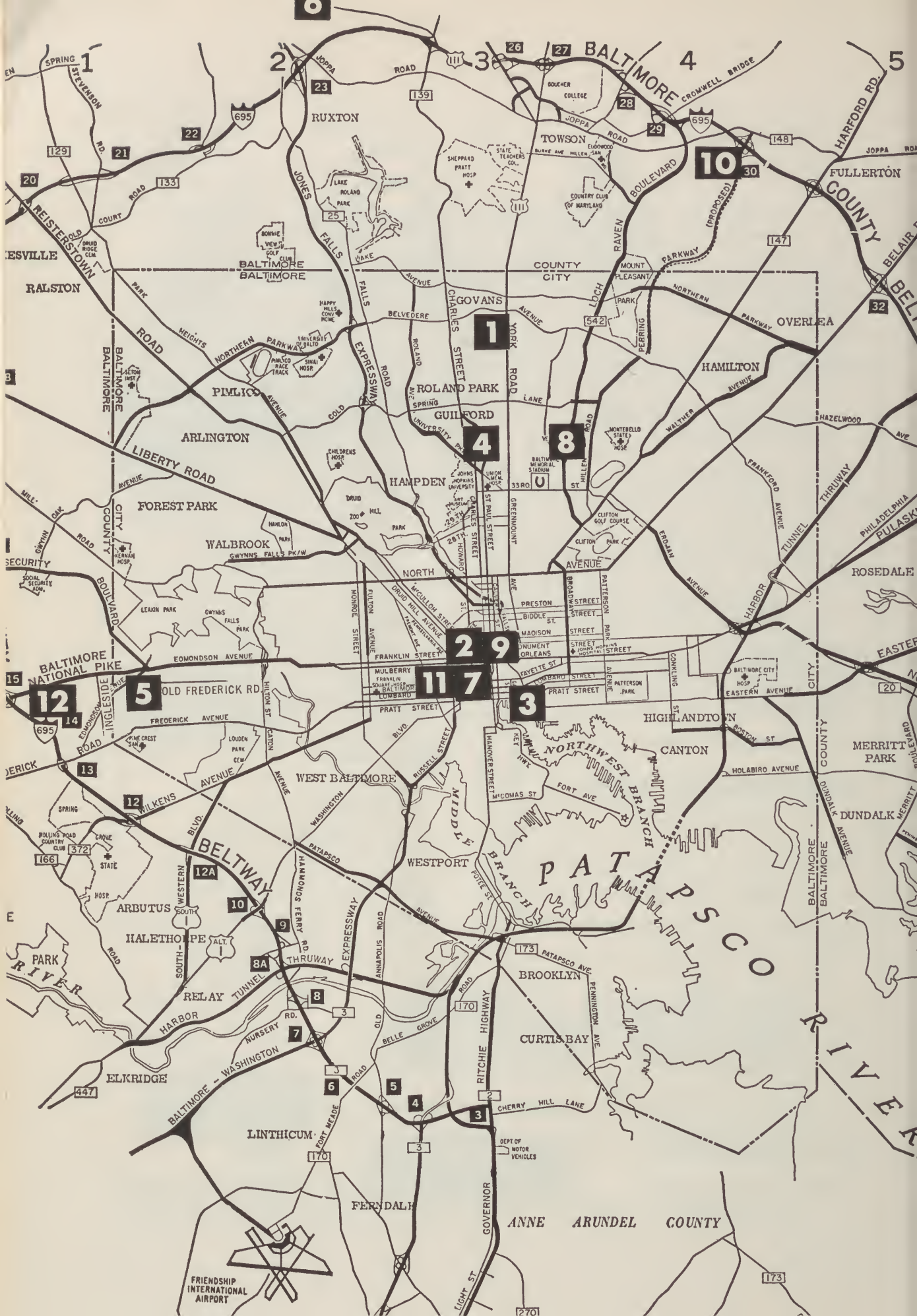


STEREO TAPE PLAYER

for CAR, BOAT or HOME



AUTO AIR CONDITIONERS
SALES and SERVICES


BALTIMORE
RUXTON
TOWSON
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
ARLINGTON
FOREST PARK
WALBROOK
PIMLICO
RALSTON
OVERLEA
HAMILTON
ROSEDALE
HIGHLANDTOWN
CANTON
MERRITT PARK
DUNDALK
BROOKLYN
CURTIS BAY
WEST BALTIMORE
WESTPORT
HALETHORPE
ARBUTUS
RELAY
ELKRIDGE
LINTHICUM
FERNDALE
ANNE ARUNDEL COUNTY
PATAPSCO RIVER
NORTHWEST BRANCH
MIDDLE BRANCH
BELTWAY
FRIENDSHIP INTERNATIONAL AIRPORT
FULLERTON
COUNTY CITY
NORTH
BALTIMORE NATIONAL PIKE
OLD FREDERICK RD.
EDMONDSON AVENUE
FREDERICK AVENUE
PRATT STREET
LIBERTY ROAD
REISTERSTOWN ROAD
CHARLES STREET
YORK ROAD
JOPPA ROAD
HARFORD RD.
CROMWELL BRIDGE
RAVEN BOULEVARD
PARKWAY
NORTHERN PARKWAY
FALLS ROAD
JONES FALLS EXPRESSWAY
HARBOR TUNNEL THRUWAY
BALTIMORE - WASHINGTON BLVD.
RITCHIE HIGHWAY
GOVERNOR
ANNAPOLIS ROAD
PATAPSCO AVE.
CHERRY HILL LANE
FORT MEADE ROAD
OLD BELLE GROVE ROAD
HANOVER STREET
MCCOMAS ST
FORT AVE
HOLABIRD AVENUE
EASTERN AVENUE
BOSTON ST
PENNINGTON AVE.
DEPT. OF MOTOR VEHICLES
LIGHT ST
1
2
3
4
5
6
7
8
9
10
11
12
2 9
11 7
1
4
8
3
10
12
5
12A
8A
695
83
95
70
97
270
447
166
372
129
133
139
147
148
542
173
170

Restaurants of Distinction

Locations indicated by numbers on map



Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS

Finest Sea Foods

Prime Meats

5653 Old Frederick Road

East of Ingleside Ave., off Baltimore National Pike

ED KUCHTA, *Manager*

Phone 744-0223

6

MILTON INN

Circa 1740

Dine Amid Early American Charm
Warm, Gracious and Inviting

Selected By Life & Time Magazines as One of America's Finest Inns

Lounge & Dining Room Available for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.

SPARKS 771-4366

---

11 *Downtown Baltimore's most renowned Italian cuisine*

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*



Your Host
Tom d'Anna

539-9021

---

3 THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

Baltimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center

Open 12 noon to 3 A.M.—Closed Mondays

For Reservations Call 685-2811

2 blocks south of the Flag House

300 ALBEMARLE STREET

Fine Restaurants

Recommended for

Your Dining Pleasure

10



SPECIAL AT THE

FABULOUS CLUB VENUS

An Evening for Two . . Only $15

Offer good every night except Saturday

Make Reservations Now

Perring Plaza Shopping Center—Beltway Exit 30

For Reservations Call NO 8-2232

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD

Cocktails Mexican Beers

Tuesday thru Sunday

Open 5:00 P.M.---12:00 P.M.

Dinner and Snacks

Closed Monday

Phone 435-9858

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

7

Miller Bros.

"The Place to Eat"



NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call **752-4822**

9

Cork 'n Bottle Restaurant

STEAK — SEAFOOD — PRIME RIB

COCKTAILS

LUNCHEON — DINNER

Major Credit Cards Honored

Private Party Rooms

22 E. FAYETTE ST. BALTIMORE, MD.

½ Block from Charles Center

539-1268

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE

Baltimore 1, Md. MU 5-6790

CARRY-OUT SERVICE

SPECIAL LUNCHEON and DINNERS

PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.

Sunday 12 Noon to 3 A.M.

4

Broadview Restaurant

Cocktails • Dinners • Luncheons

Private Entertaining Facilities

116 W. University Parkway at 39th St.

CALL CH 3-1216

Expansion of Sheppard-Pratt Hospital Underway

Unlike many originators whose plans are initiated according to chance and challenge, Moses Sheppard had the foresight to know his work would grow after him. So he designed an institution of simplicity and practicality amid pleasant surroundings. The institution was to be a haven for the mentally disturbed—the troubled, the anxious, the hysterical, the manic, and the depressed. It would also house trained personnel who, with the aid of medical science, could help the individual return to his home and family, confident that he can cope with life. Everything was to be done for the comfort and recovery of the patient.

That was in 1858. Since then, many others have furthered his work, including Enoch Pratt who now shares the name of the institution—The Sheppard and Enoch Pratt Hospital. But his work has not ceased; it continues today. With the need for renovations, facilities for educational and consultative work, outpatient services, psychiatric training of doctors, nurses, and social workers, and the increase in educational work with disturbed children and adolescents, comes the need for expansion. This is what the cornerstone laying of the hospital's new central building was all about.

The ceremony took place on May 13, 1969, at which Governor Mandel was featured speaker. State officials, trustees, and other notables were also present. Hopefully, this building will help to meet these present needs.



Featured speaker at the cornerstone laying ceremony was Governor Marvin Mandel. On his right are Anthony J. Ianniello (hidden by the podium) architect for the New Central Building of the hospital; John Sargeant, Executive Secretary of the Medical and Chirurgical Faculty, and Robert W. Gibson, MD, Medical Director of the hospital.

MEDICAL NEWS

The Commonwealth Fund and the Carnegie Corporation of New York have jointly announced grants which will enable five of North America's leading medical schools to launch a collaborative program, including the education of a new type of clinical physician, aimed at improving systems and institutions for providing medical care and health services.

The collaborative program is being developed under the supervision of the Departments of Medicine of the five schools—including **Julius R. Krevans, MD, of Johns Hopkins**—and is underwritten by a $250,000 grant from the Carnegie Corporation and $298,100 from the Commonwealth Fund.

Dr. Krevans is a professor of medicine at The Johns Hopkins University School of Medicine, and has recently been named Dean of Academic Affairs of the medical school. He also serves as Physician-in-Chief at Baltimore City Hospitals.

* * *

The trustees of the Caleb Fiske Prize Essay of the Rhode Island Medical Society have announced as the subject for this year's dissertation, "Medical Education In The Years Ahead." A cash prize of $500 is offered. Essays must be submitted by December 15, 1969.

For further information, write to the Secretary, Caleb Fiske Fund, Rhode Island Medical Society, 106 Francis Street, Providence, Rhode Island 02903.

* * *

The Baltimore County Medical Association recently held an "open house" at its new office, 8523 Loch Raven Boulevard, in the Baynesville area of Baltimore County.

* * *



Dr. Solomon

Stressing urgent manpower needs and the multitude of Maryland's social problems, **Dr. Neil Solomon,** newly appointed Secretary of Health and Mental Hygiene, said that he will be asking members of the professional staffs of the departments under his control to participate as widely as possible in community activities.

Dr. Solomon said that he expects to make a personal contribution himself by continuing his already numerous appearances as a public service and by continuing, on a limited basis, a research project which he has been conducting on metabolic disorders. He explained that this research project is supported entirely by the contributions of patients who are participating in it.

* * *

Louis Padovano, MD, has been ordained a priest in the Society of Jesus (Jesuits). He began studies for ordination to the priesthood in 1964, after receiving his MD from Georgetown University School of Medicine in 1956. Dr. Padovano has also completed two tours of duty in Viet Nam.

* * *

Frederick L. Wehr has been re-elected president of The Children's Hospital, Greenspring Avenue, for his 11th term.

Re-elected Medical Director of the hospital was **George O. Eaton, MD;** and **Edmond McDonnell, MD,** was re-elected assistant medical director.

* * *

The following members of the American Society of Anesthesiologists have recently been made Fellows of the American College of Anesthesiologists: **Manuel Jesus Balseiro, MD,** of Silver Spring; **Harry Cohen, MD,** Baltimore; **Jack Egnatinsky, MD,** Annapolis, and **Richard Paul Strader, MD,** of Bethesda.

* * *

Recently appointed Chief of the Division of Communicable Diseases in the State Health Department is **Howard J. Garber, MD.** Dr. Garber will also direct two Public Health Service grants within the State Health Department. One is an immunization project and the other is a venereal disease control program.

Previously, Dr. Garber was an epidemic intelligence service officer for the United States Public Health Service assigned to Maryland.

Dr. Garber succeeds **John H. Janney, MD,** who will continue as a consultant to the division.

* * *

The *American Medical News* made its appearance with the July 7 issue. It succeeds the *AMA News,* which began in 1958 as a biweekly, became a weekly in 1965, and appeared 398 times in its 11-year existence.

From an initial circulation of 224,450, the newspaper has grown to its present press run of 350,000 copies weekly. It is received by physicians, students in the final three years of medical school, members of the allied health professions, and others.

Marvin L. Rowlands heads the staff and Dick Walt is executive director.

* * *

Richard Bauer, MD, has been named President of the Prince George's General Hospital Medical Staff. Named as Vice President was **William Holbrook, MD.**

Dr. Bauer, a past president of the Prince George's County Medical Society, is also past president of the Medical and Chirurgical Faculty of the State of Maryland. He is a graduate of Haverford College in Haverford, Pa., and received his MD degree from Jefferson Medical College.

* * *

The Surgeon General's Scientific Advisory Committee on Television and Social Behavior held its first organizational meeting in June 16-17, 1969, in Chevy Chase, Maryland. William H. Stewart, MD, US Public Health Service Surgeon General, gave the Committee its charge: ". . . provide consultation and guidance on a scientific study of the relationship between televised crime and violence and antisocial behavior, with special emphasis on children."

Dr. Stewart announced that Eli A. Rubinstein, MD, Assistant Director for Extramural Programs and Behavioral Sciences, National Institute of Mental Health, will be Vice Chairman and that Mr. Richard A. Moore, Special Consultant to the Secretary, Department of Health, Education, and Welfare, will provide coordination between the Committee and the Office of the Secretary.

* * *



Dr. Heptinstall

Robert H. Heptinstall, MD, has been named Baxley Professor of Pathology and director of the department of pathology at The Johns Hopkins University School of Medicine, and Pathologist-in-Chief for The Johns Hopkins Hospital. He assumed his new positions July 1, 1969.

Born in England, Dr. Heptinstall received his medical education at Charing Cross Hospital Medical School in London. He was an outstanding student, winning the class prizes in medicine and surgery during his second and third year.

* * *

The first total hip replacement with an American-designed prosthesis was performed on June 27 at the University of Maryland Hospital.

The patient, a 46-year-old Baltimore laborer, was the first person in Maryland to receive an entirely new hip—both the ball and the socket of the joint. In a more common operation, called a cup orthroplasty, a metal liner is placed in the hip socket.

Thomas H. Morgan, MD, who performed the operation using a prosthesis of his own design, headed the orthopedic unit at Princess Margaret Hospital in England before coming to Baltimore in 1966 to join the staff of the University of Maryland School of Medicine. Two hip models designed by British orthopedists are in use there, he said, and have been used to a limited degree in research programs in this country.

* * *

Herbert B. Copeland, MD, Nathan B. Hyman, MD, Albert B. Shackman, MD, Nathan Stofberg, MD, and **Martin J. Birnbaum, MD,** have announced the association of **Larry A. Snyder, MD,** in the private practice of diagnostic radiology.

* * *

Melvin B. Davis, MD, medical examiner for Baltimore County's southeast district and a general practitioner in Dundalk, has been appointed to the county Board of Health.

Dr. Davis received his medical degree from the University of Maryland School of Medicine in 1931, interned at the University Hospital, and studied anesthesiology at the Lahey Clinic in Boston.

* * *

Norton Spritz, MD, has been appointed Professor of Medicine at New York University School

of Medicine. A 1952 graduate of the University of Maryland School of Medicine, Dr. Spritz has held teaching and research appointments at Cornell University Medical College and The Rockefeller University.

* * *

The Maryland Tuberculosis and Respiratory Disease Association offers a free tuberculin test (Mantoux Intermediate PPD) to any person reporting to the Association Screening Clinic for a chest X-ray. The test will be given by a registered nurse and interpreted by the writer. A chest X-ray will be required of all persons over 15 years of age who are skin tested.

* * *

The American Academy of Pediatrics has taken a major step to improve the delivery of child health care in the United States by initiating a national program to train allied child health personnel, including pediatric nurse associates, pediatric office assistants, and pediatric aides.

To implement this program, the Academy Executive Board approved the establishment of a Division of Child Health Manpower within the AAP Central Office.

* * *

The development and extension of community-based facilities to treat and rehabilitate narcotic addicts has been given major impetus with the announcement of the availability of funds under a new program recently authorized by Congress.

Staffing grants are now available to nonprofit agencies for the operation of addict treatment and rehabilitation facilities.

The National Institute of Mental Health, which will administer the grant program, has issued preliminary guidelines to assist eligible community agencies in developing plans for treatment programs. Final regulations will be promulgated by the Department of Health, Education, and Welfare.

* * *

H. M. Robinson, MD, head of the division of dermatology, and **John H. Stone, MD,** senior resident in dermatology, University of Maryland School of Medicine, presented a paper at the July meeting of the American Medical Association in New York.

* * *

Joseph W. Burnett, MD, associate professor of dermatology, and **Drs. Ronald Goldner** and **Mouta Al-Dilaimy,** both residents in dermatology, University of Maryland School of Medicine, presented a paper at the meeting of the Society of Investigative Dermatology in New York, July 27.

The division of dermatology sponsored a symposium on "Rehabilitation in Dermatology" for physicians, attorneys, rehabilitation counselors, and social service workers on May 7.

* * *

Ephraim T. Lisansky, MD, associate professor of medicine, University of Maryland School of Medicine, participated in a conference in Colombia sponsored by the American College of Physicians in March.

* * *

Albert F. Heck, MD, associate professor of neurology, University of Maryland School of Medicine, was elected a fellow of the International College of Angiology.

* * *

Josephine Buca, assistant professor of physical therapy, will represent the University of Maryland School of Medicine on the advisory committee for the physical therapy assistants curriculum at the Community College of Baltimore.

* * *

Robert L. Derbyshire, MD, associate professor of sociology in psychiatry, and **Gerard Hunt, MD,** assistant professor of sociology in psychiatry, both of the University of Maryland, participated in the Southern Regional Education Board Conference on "Research in Adaptation of Migrants" in Atlanta, March 6-8.

* * *



Dr. Holcomb

Thomas H. Holcomb, MD, has been named Director of Pediatrics at the Franklin Square Hospital. Dr. Holcomb is a graduate of the University of Vermont College of Medicine and he has a Master of Public Health degree in maternal care and child health from The Johns Hopkins University School of Public Health and Hygiene. He completed his internship and residency at Vassar Brothers Hospital in Poughkeepsie, New York. He has also been a resident at Baltimore City Hospitals in pediatrics.

* * *

Frank T. Rafferty, MD, director of the division of child psychiatry at the University of Maryland School of Medicine, was one of three keynote speakers at a Legislative Forum in Raleigh, North Carolina, March 24-26.

* * *

Eugene B. Brody, MD, director of The Psychiatric Institute, has been appointed to the editorial board of *Mental Hygiene,* Journal of the National Association for Mental Health.

* * *

Virginia Huffer, MD, associate professor of psychiatry at the University of Maryland, has been appointed secretary of the Baltimore-District of Columbia Society for Psychoanalysis.

* * *

Naomi Rae-Grant, MD, assistant director of the division of child psychiatry at the University of Maryland School of Medicine presented a paper at the Alpha Omega Alpha meeting in New York, April 1.

* * *

Constantine Sakles, MD, assistant professor of psychiatry at the University of Maryland, delivered a paper at the annual meeting of the American Society of Group Psychotherapy and Psychodrama in New York, April 25.

* * *

William G. Esmond, MD, assistant professor of surgery at the University of Maryland, in association with **Thomas Regan, MD,** of the department of chemical engineering in College Park, presented a paper at the meeting of the American Chemical Society in Minneapolis, April 17.

* * *

Julio E. Alarcon, MD, resident in obstetrics and gynecology at the University of Maryland Hospital, was awarded both third prize and honorable mention in the 11th annual SAMA-EATON Medical Art Competition, sponsored by the Student American Medical Association and the Eaton Laboratories.

* * *

Jean Dockhorn, director of the department of social work at the University of Maryland Hospital, has been elected chairman of the newly organized Maryland Chapter of the American Society for Hospital Social Work Directors.

* * *

Margaret R. Gambrill, a doctoral candidate in microbiology was awarded the Graduate Prize of the University of Maryland's chapter of the American Association of University Women as the most outstanding woman doing predoctoral research at the university.

* * *

Medical and Chirurgical Faculty of Maryland

HOTEL HERSHEY

September 4, 5, 6, 1969

PLEASE CHECK THE APPROPRIATE SPACES AND RETURN PROMPTLY TO:

Mr. Harvey S. Schell, Reservations Manager
Hotel Hershey, Hershey, Pennsylvania 17033

ROOM RATES: AMERICAN PLAN, WITH MEALS

Twin-bedded rooms .....$24.00 per person per day—2 in a room

Single rooms .....$27.00 per person per day

(A 15% Gratuity to be added to the above rates. This takes care of the Dining Room Personnel on food only, bellmen for check in and out, maids and doormen. Individuals to do other tipping on their own, such as room service, beverage bills, etc.)

PLEASE RESERVE THE FOLLOWING ACCOMMODATIONS:

.....Twin bedded rooms

.....Single rooms

..... NAME OF MEMBER SHARING ROOM

ARRIVAL DATE..... DEPARTURE DATE.....
(ROOMS NOT AVAILABLE UNTIL 4:00 P.M.) (1:00 P.M. CHECK OUT TIME)

.....
DATE



MEDIC

1969-1970 SCHEDULE OF POSTGRADUATE PROGRAMS
presented through
Medical Education's Dedicated Instructional Channel

SEPTEMBER 26, 1969 — 12:30 PM

USES AND ABUSES OF ANTIBIOTICS

Patricia Charache, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Large numbers of new antibiotics have been presented to the physician within the past few years, many associated with heavy advertising pressures. This discussion will consider methods of evaluating antibiotics in order to tailor drug usage to the needs of a particular patient and in order to avoid drug abuse.

Sponsor: FREDERICK MEMORIAL HOSPITAL
Replays: Monday, September 29, 1969 — 12:30 PM
Wednesday, October 1, 1969 — 9:00 AM
2:00 PM

OCTOBER 3, 1969 — 12:30 PM

NURSERY CARE FOR THE NEWBORN

Marvin Cornblath, MD
Professor and Head
Department of Pediatrics
University of Maryland School of Medicine

The first minutes are the most critical in the life of the newborn. Having survived the first twenty-four hours, life expectancy is at the highest peak ever. Emphasis will be placed on the care of the newborn for the first minutes and hours of life.

Sponsor: SACRED HEART HOSPITAL
Replays: Monday, October 6, 1969 — 12:30 PM
Wednesday, October 8, 1969 — 9:00 AM
2:00 PM

OCTOBER 10, 1969 — 12:30 PM

PACEMAKERS

J. O'Neal Humphries, MD
Assistant Profressor of Medicine
The Johns Hopkins University School of Medicine

Artificial pacing is the preferred management for patients with symptoms due to complete heart block, including syncope, near-syncope, congestive failure, azotemia, confusion and lethargy. Acceptable reliability allows the continuous use of the pulse generator unit for two to two and one-half years. Artificial pacing may be the preferred method of management for selected patients with paroxysmal tachycardia or sinus bradycardia. Seven years experience with over 200 patients treated with permanent artificial pacemakers will be presented. Demand pacing through endocardial electrodes (position transvenously) is used in most instances at the present time.

Sponsor: GREATER BALTIMORE MEDICAL CENTER
Replays: Monday, October 13, 1969 — 12:30 PM
Wednesday, October 15, 1969 — 9:00 AM
2:00 PM

OCTOBER 17, 1969 — 12:30 PM

MYOCARDIAL INFARCTION

Gustav C. Voigt, MD
Assistant Chief of Medicine
Baltimore City Hospitals
John R. Wright, MD
Assistant Chief of Pathology
Baltimore City Hospitals

This discussion will emphasize the pathophysiology of myocardial infarction and possible complications. Also in this discussion a patient with myocardial infarction will be presented.

Sponsor: BALTIMORE CITY HOSPITALS
Replays: Monday, October 20, 1969 — 12:30 PM
Wednesday, October 22, 1969 — 9:00 AM
2:00 PM

OCTOBER 24, 1969 — 12:30 PM

INFECTIOUS MONONUCLEOSIS

Dexter Seto, MD
Assistant Professor of Pediatrics
The Johns Hopkins University School of Medicine

This discussion will cover several clinical aspects of infectious mononucleosis, the various manifestations and complications, and laboratory aids in diagnosis. Current concepts in etiology will also be considered.

Sponsor: FREDERICK MEMORIAL HOSPITAL
Replays: Monday, October 27, 1969 — 12:30 PM
Wednesday, October 29, 1969 — 9:00 AM
2:00 PM

Supported in part by a grant from Merck, Sharp and Dohme

OCTOBER 31, 1969 — 12:30 PM
ALCOHOLISM

Roland Smoot, MD
Chief of Medicine
Provident Hospital
Maxwell N. Weisman, MD
Director, Division of Alcoholism Control
State Department of Mental Hygiene

The program will discuss the specific role of the general hospital in coping with the acute phase of alcoholism, but will also consider the responsibility of other community agencies which may serve as allies to the physician in managing the chronic illness within the framework of a comprehensive public health program.

Sponsor: PROVIDENT HOSPITAL
Replays: Monday, November 3, 1969 — 12:30 PM
Wednesday, November 5, 1969 — 9:00 AM
2:00 PM

NOVEMBER 7, 1969 — 12:30 PM
OVARIAN DYSFUNCTION

Georgeanna Seegar Jones, MD
Associate Professor of Obstetrics and Gynecology
The Johns Hopkins University School of Medicine

Ovarian dysfunction can be clinically characterized by irregular or absent periods or prolonged or profuse menses. The decision as to whether or not the symptons require investigation or treatment must be made on the basis of the individual case. When primary amenorrhea exists, it is always important to determine if an associated abnormality of the genitalia exists. No intelligent approach can be made to therapy of ovarian dysfunction until a proper etiologic diagnosis has been obtained. With the addition of human pituitary gonadotrophin and clomiphene citrate to our therapeutic armimentarium, the results of therapy are more encouraging.

Sponsor: SACRED HEART HOSPITAL
Replays: Monday, November 10, 1969 — 12:30 PM
Wednesday, November 12, 1969 — 9:00 AM
2:00 PM

NOVEMBER 14, 1969 — 12:30 PM
PROBLEMS OF POLYARTHRITIS

Mary Betty Stevens, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Patients with acute polyarthritis of recent onset present difficult problems in diagnosis and management. The approach to differential diagnosis, clinical and laboratory study, will be discussed. Therapeutic regimens and philosophy of management will be outlined. Individual cases of illustrative value will be presented.

Sponsor: GREATER BALTIMORE MEDICAL CENTER
Replays: Monday, November 17, 1969 — 12:30 PM
Wednesday, November 19, 1969 — 9:00 AM
2:00 PM

NOVEMBER 21, 1969 — 12:30 PM
PRE-ECLAMPSIA AND ECLAMPSIA

Frank Kaltreider, MD
Chief, Department Obstetrics and Gynecology
Baltimore City Hospitals
Rafael Garcia, MD
Assistant Chief of Pathology
Baltimore City Hospitals

Pre-eclampsia is a preventable disease. Pre-eclampsia is commonly associated with varied complications. For these reasons warning signs, apparently innocent, cannot be ignored.

Sponsor: BALTIMORE CITY HOSPITALS
Replays: Monday, November 24, 1969 — 12:30 PM
Wednesday, November 26, 1969 — 9:00 AM
2:00 PM

NOVEMBER 28, 1969 — 12:30 PM
CURRENT IMMUNIZATION PRACTICES

David H. Carver, MD
Associate Professor of Pediatrics and
Associate Professor of Microbiology
The Johns Hopkins University School of Medicine

This discussion will deal with a suggested schedule of immunization of children and will emphasize particularly the new vaccines, mainly measles, mumps, and rubella.

Sponsor: FREDERICK MEMORIAL HOSPITAL
Replays: Monday, December 1, 1969 — 12:30 PM
Wednesday, December 3, 1969 — 9:00 AM
2:00 PM

DECEMBER 5, 1969 — 12:30 PM
OBESITY

Simeon Margolis, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine
University of Maryland School of Medicine

An increasing number of patients are turning to physicians for assistance in weight reduction and for treatment of the complications of obesity. Management of the obese patient is an extremely frustrating medical problem but may involve dietary, drug, and psychiatric measures. This talk will cover the pathogenesis, complications, and management of obesity.

Sponsor: SACRED HEART HOSPITAL
Replays: Monday, December 8, 1969 — 12:30 PM
Wednesday, December 10, 1969 — 9:00 AM
2:00 PM

DECEMBER 12, 1969 — 12:30 PM
INTERPRETATION OF BRAIN SCANS

Frank H. DeLand, MD
Assistant Professor of Radiology
The Johns Hopkins University School of Medicine

The accumulation of experience over the past decade has enabled us to characterize abnormal accumulations of radioactivity. Histologic diagnosis cannot be made from the brain scans when an abnormal accumulation, as seen in a scan, is nonspecific. However, the nature of the lesion can be inferred based on its scan characteristics of size, shape, concentration of activity and location.

Sponsor: GREATER BALTIMORE MEDICAL CENTER
Replays: Monday, December 15, 1969 — 12:30 PM
Wednesday, December 17, 1969 — 9:00 AM
2:00 PM

DECEMBER 19, 1969 — 12:30 PM
TUBERCULOUS MENINGITIS

Edmund G. Beacham, MD
Assistant Professor of Medicine and
Chief, Tuberculosis Division
Baltimore City Hospitals
Richard Slavin, MD
Assistant Chief of Pathology
Baltimore City Hospitals

Tuberculous meningitis in children and adults will be approached by both clinical and pathological application.

Sponsor: BALTIMORE CITY HOSPITALS
Replays: Monday, January 5, 1970 — 12:30 PM
Wednesday, January 7, 1970 — 9:00 AM, 2:00 PM

JANUARY 9, 1970 — 12:30 PM
GIANT CELL ARTERITIS

Philip A. Tumulty, MD
Professor of Medicine
The Johns Hopkins University School of Medicine

Giant cell arteritis proves to be a systemic illness of major significance. The natural history, problems in differential diagnosis, unusual clinical manifestations and treatment will be emphasized.

Sponsor: GREATER BALTIMORE MEDICAL CENTER
Replays: Monday, January 12, 1970 — 12:30 PM
Wednesday, January 14, 1970 — 9:00 AM, 2:00 PM

JANUARY 16, 1970 — 12:30 PM
GLOMERULONEPHRITIS

C. Robert Cooke, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine
Abou D. Pollack, MD
Chief of Pathology
Baltimore City Hospitals
Associate Professor of Pathology
The Johns Hopkins University School of Medicine

Acute glomerulonephritis will be considered from the standpoint of diagnosis and management. Correlation of the symptomatology with the pathological findings in a representative case will be presented.

Sponsor: BALTIMORE CITY HOSPITALS
Replays: Monday, January 19, 1970 — 12:30 PM
Wednesday, January 21, 1970 — 9:00 AM, 2:00 PM

JANUARY 23, 1970 — 12:30 PM
STERILIZATION, PREP AND ISOLATION TECHNIQUES

John J. White, MD
Assistant Professor of Pediatric Surgery
The Johns Hopkins University School of Medicine

It is becoming apparent that infections are more frequently due to organisms endogenous to the patient himself than to contamination from his surroundings. Current aseptic methods range from those based on established evidence, through those that lack good evidence but appear rational, to those that seem to be based on ritual. Prepping solutions and techniques, isolation and protection systems, and sterilization will be discussed.

Sponsor: FREDERICK MEMORIAL HOSPITAL
Replays: Monday, January 26, 1970 — 12:30 PM
Wednesday, January 28, 1970 — 9:00 AM, 2:00 PM

JANUARY 30, 1970 — 12:30 PM
PORTAL CIRRHOSIS

George Zuidema, MD
Professor of Surgery
The Johns Hopkins University School of Medicine

The major life-threatening complication of hepatic cirrhosis is hemorrhage from gastroesophageal varices. Precise diagnosis and aggressive primary care are essential in successful patient management. Although many methods have been employed, emergency portacaval anastomosis remains the best method for control of variceal hemorrhage and definitive treatment of portal hypertension. Portal decompression also has a role in control of intractable cirrhotic ascites.

Sponsor: PROVIDENT HOSPITAL
Replays: Monday, February 2, 1970 — 12:30 PM
Wednesday, February 4, 1970 — 9:00 AM, 2:00 PM

FEBRUARY 6, 1970 — 12:30 PM
MENINGITIS

Fred McCrumb, MD
Professor of International Diseases
University of Maryland School of Medicine

Acute microbial disease of the central nervous system is manifested most frequently as the clinical syndrome of meningitis. A broad spectrum of bacterial and viral agents may be involved thus presenting varied and specific diagnostic problems. The prevalence, specific identification, pathogenesis, and clinical management will be discussed.

Sponsor: SACRED HEART HOSPITAL
Replays: Monday, February 9, 1970 — 12:30 PM
Wednesday, February 11, 1970 — 9:00 AM, 2:00 PM

FEBRUARY 13, 1970 — 12:30 PM
MALABSORPTION

Thomas R. Hendrix, MD
Professor of Medicine
The Johns Hopkins University School of Medicine

The differential problem represented by the presence of malabsorption in the adult will be reviewed, as well as material from the G.I. Clinic at The Johns Hopkins Hospital.

Sponsor: GREATER BALTIMORE MEDICAL CENTER
Replays: Monday, February 16, 1970 — 12:30 PM
Wednesday, February 18, 1970 — 9:00 AM, 2:00 PM

FEBRUARY 20, 1970 — 12:30 PM
SUBACUTE BACTERIAL ENDOCARDITIS

Patricia Charache, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine
Abou D. Pollack, MD
Chief of Pathology
Baltimore City Hospitals, and
Associate Professor of Pathology
The Johns Hopkins University School of Medicine

The clinical and microbial diagnosis of subacute bacterial endocarditis, as well as the management of the patient with subacute endocarditis are to be presented.

Sponsor: BALTIMORE CITY HOSPITALS
Replays: Monday, February 23, 1970 — 12:30 PM
Wednesday, February 25, 1970 — 9:00 AM, 2:00 PM

FEBRUARY 27, 1970 — 12:30 PM
HEPATITIS

Robert H. Drachman, MD
Assistant Professor of Microbiology and
Assistant Professor of Pediatrics
The Johns Hopkins University School of Medicine

Hepatitis, as a disease entity, ranges from the subclinical to a fulminating lethal infection. Its frequency and age of distribution makes it a concern of all physicians. Basic considerations, as well as newer aspects of this entity will be presented.

Sponsor: FREDERICK MEMORIAL HOSPITAL
Replays: Monday, March 2, 1970 — 12:30 PM
Wednesday, March 4, 1970 — 9:00 AM, 2:00 PM

MARCH 6, 1970 — 12:30 PM
THE DEPRESSED PATIENT

Frank Ayd, Jr., MD
Diplomate in Psychiatry
Baltimore, Maryland

Of all the ills to which man is heir, depression occurs with the greatest frequency. The objective of this presentation is to present the cardinal symptoms of endogenous melancholia and to review various methods of managing patients with this illness. Special attention is given to the art of using chemical remedies for melancholia.

Sponsor: SACRED HEART HOSPITAL
Replays: Monday, March 9, 1970 — 12:30 PM
Wednesday, March 11, 1970 — 9:00 AM, 2:00 PM

MARCH 13, 1970 — 12:30 PM
INDICATIONS FOR TRACHEOSTOMY IN MEDICAL PATIENTS

Douglas G. Carroll, MD
Chief of Physical Medicine and Rehabilitation
Baltimore City Hospitals

Tracheostomy is being used increasingly in hospitalized medical patients for short term treatment of ventilatory insufficiencies and inability to clear secretions adequately. The indications and complications of tracheostomy will be discussed, based on experience at the Baltimore City Hospitals.

Sponsor: GREATER BALTIMORE MEDICAL CENTER
Replays: Monday, March 16, 1970 — 12:30 PM
Wednesday, March 18, 1970 — 9:00 AM, 2:00 PM

MARCH 20, 1970 — 12:30 PM
COIN LESION IN THE CHEST

Jack Love, MD
Chief of Thoracic and Cardiovascular Surgery
Baltimore City Hospitals
John R. Wright, MD
Assistant Chief of Pathology
Baltimore City Hospitals

In this discussion, a patient with a pulmonary coin lesion will be presented. The management and differential diagnosis of such a patient will be the center of concentration.

Sponsor: BALTIMORE CITY HOSPITALS
Replays: Monday, March 23, 1970 — 12:30 PM
Wednesday, March 25, 1970 — 9:00 AM, 2:00 PM

MARCH 27, 1970 — 12:30 PM
HISTOPLASMOSIS

Henry V. Chase, MD
Department of Medicine
Frederick Memorial Hospital

The early history of histoplasmosis will be discussed and illustrated, with emphasis on those aspects related to Maryland and Virginia. Epidemiological studies will be described and several recent surveys in this area will be mentioned. Available diagnostic tests and methods of treatment will be reviewed.

Sponsor: FREDERICK MEMORIAL HOSPITAL
Replays: Monday, March 30, 1970 — 12:30 PM
Wednesday, April 1, 1970 — 9:00 AM, 2:00 PM

APRIL 10, 1970 — 12:30 PM
MALNUTRITION

George C. Graham, MD
Associate Professor of Pediatrics and
Professor of International Health
The Johns Hopkins University School of Medicine

Forms of malnutrition exist in all societies. Neither the deprived nor affluent are immune to the ramifications of this disease. Data on and consideration of the problem as it exists today will be presented.

Sponsor: GREATER BALTIMORE MEDICAL CENTER
Replays: Monday, April 13, 1970 — 12:30 PM
Wednesday, April 15, 1970 — 9:00 AM, 2:00 PM

APRIL 17, 1970 — 12:30 PM
ECTOPIC PREGNANCY

Harold Misenheimer, MD
Associate Chief of Obstetrics and Gynecology
Baltimore City Hospitals
Rafael Garcia, MD
Assistant Chief of Pathology
Baltimore City Hospitals

This presentation will emphasize the salient diagnostic features of ectopic pregnancy. The danger of missing an ectopic pregnancy in diagnosis will be discussed. The typical pathologic patterns found with an ectopic pregnancy will be discussed.

Sponsor: BALTIMORE CITY HOSPITALS
Replays: Monday, April 20, 1970 — 12:30 PM
Wednesday, April 22, 1970 — 9:00 AM, 2:00 PM

APRIL 24, 1970 — 12:30 PM
TUBERCULOSIS AND ATYPICAL MYCOBACTERIA

Edmund G. Beacham, MD
Chief, Tuberculosis Division
Baltimore City Hospitals
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Discussion will be centered on clinical aspects of pulmonary tuberculosis including disease caused by atypical mycobacteria. Comments will cover tuberculin tests, differential diagnosis, and drug treatment.

Sponsor: FREDERICK MEMORIAL HOSPITAL
Replays: Monday, April 27, 1970 — 12:30 PM
Wednesday, April 29, 1970 — 9:00 AM, 2:00 PM

MAY 1, 1970 — 12:30 PM
HIATAL HERNIA

Vernon Smith, MD
Chief of Medicine
Mercy Hospital

The discussion will deal mainly with symptomatic sliding esophageal hiatus hernia and associated esophagitis. Practical aspects of diagnosis and management will be developed from known pathologic mechanisms. Special attention will be directed toward a critical review of various operations advocated for treatment of hiatal hernia, and toward the rational selection of patients for operation.

Sponsor: SACRED HEART HOSPITAL

Replays:	Monday, May 4, 1970	12:30 PM
	Wednesday, May 6, 1970	9:00 AM
		2:00 PM

MAY 8, 1970 — 12:30 PM
GRAND ROUNDS

Thaddeus Prout, MD
Chief of Medicine
Greater Baltimore Medical Center and
Associate Professor of Medicine
The John Hopkins University School of Medicine

Several interesting cases illustrating some of the problems for diagnosis and therapy that have been seen will be discussed.

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:	Monday, May 11, 1970	12:30 PM
	Wednesday, May 13, 1970	9:00 AM
		2:00 PM

MAY 15, 1970 — 12:30 PM
HEMOPTYSIS

Kenneth Lewis, MD
Chief, Cardiovascular Division
Baltimore City Hospitals
Richard Slavin, MD
Assistant Chief of Pathology
Baltimore City Hospitals

Hemoptysis may be caused by primary disease of the lung, or diseases that produce secondary pulmonary changes. The clinical and pathological features of a patient presenting with hemoptysis will be discussed.

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, May 18, 1970	12:30 PM
	Wednesday, May 20, 1970	9:00 AM
		2:00 PM

MAY 22, 1970 — 12:30 PM
GRAM NEGATIVE SEPTICEMIA

Richard B. Hornick, MD
Assistant Professor of Medicine and
Director, Division of Infectious Diseases
University of Maryland School of Medicine

Infectious diseases caused by gram-negative rods have been emerging as the most common type of hospital acquired infection, as well as the most difficult to treat. Previously, *E. coli* was the most common offender but in recent years, the incidence of this has dropped and has been replaced by Klebsiella species and less common organisms like *Serratia Marscius.* New sources of organisms like humidifiers have caused gram-negative rod respiratory infections. New trends in the management of these serious illnesses will be discussed.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:	Monday, May 25, 1970	12:30 PM
	Wednesday, May 27, 1970	9:00 AM
		2:00 PM

MAY 29, 1970 — 12:30 PM
HEMOGLOBINOPATHIES

Julius Krevans, MD
Professor of Medicine
The Johns Hopkins University School of Medicine

The relationship between the genetic control of protein structure and the biological function is nowhere better illustrated than in the abnormality of erythrocytes known as the hemoglobinopathies. Examples will be chosen to illustrate a continuous chain from molecular change to manifestations of disease.

Sponsor: PROVIDENT HOSPITAL

Replays:	Monday, June 3, 1970	12:30 PM
	Wednesday, June 5, 1970	9:00 AM
		2:00 PM

(See next page for a list of participating hospitals)

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

September 23 November 25 January 27 February 24 March 24 April 28 May 26

OTHER SPONSORS:

Medical and Chirurgical Faculty of the State of Maryland
State Department of Health
Hospital Council of Maryland

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Physicians Memorial, LaPlata
Prince George's General, Cheverly
Provident, Baltimore
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Veterans Administration, Loch Raven, Baltimore
Washington County, Hagerstown

Other locations:

Baltimore County Health Dept., Towson
Civil Defense Headquarters, Baltimore
Hospital Council of Maryland, Inc., Baltimore
Medical and Chirurgical Faculty, Baltimore
State Department of Health, Baltimore

For further information contact:

Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
539-0872.

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201 383-3010 Ext. 8722

Additional programs published monthly in
Maryland State Medical Journal

Supported in part by a grant from Merck, Sharp and Dohme



CCTV TOTAL SYSTEMS

PLANNING, ENGINEERING, INSTALLATION & SERVICE

We Feature **AMPEX**

VIDEOTAPE RECORDING EQUIPMENT

Call Today for a Free Demonstration

high fidelity house

6307 YORK ROAD BALTIMORE, MD.
(Drumcastle)

Phone 323-3713

D S

DOCTORS SUPPLY COMPANY

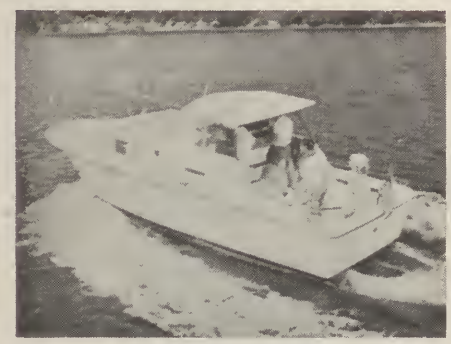
All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222



CONCORDE

The Custom Line of Fiberglas
by *Brunswick*
27′ to 47′

VENTNOR MARINE SERVICE

Ventnor Road Pasadena, Md.

255-4100

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ INGLESIDE SHOPPING CENTER
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ HILLENDALE SHOPPING CENTER
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our *2 All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

APRIL 1, 2, 3, 1970

The Alcazar, Baltimore

As space is limited, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

7. Name of institution cooperating in the exhibit: _____

_____

8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS

AHA Editorial: "Hospitals Challenged by Poor"

Comprehensive health care for all will only be achieved when the providers of health services become totally involved with the people they seek to serve, an editorial in the July 1 issue of HOSPITALS, Journal of the American Hospital Association, declares.

The AHA editorial points out that the nation's hospitals are being challenged by poor people to use their resources and ability to respond both to health needs and to other social needs.

The entire issue of HOSPITALS is devoted to the delivery of health care services to the poor. Articles explore the need for hospital involvement in delivering those services, and discuss ways in which hospitals can take a leading role in producing the best possible system of comprehensive health care.

According to the editorial, "massive attacks on the nation's health problems through Medicare, Medicaid and Regional Medical Programs, etc. have helped those least who need help most."

"White middle-class society still hasn't completed its lesson on social equality of different ethnic groups," the editorial says, "although the providers of governmental service are beginning to realize that the only way to govern peacefully in a democratic society is to ensure involvement of all the groups governed."

The editorial adds: "The lesson to providers of health care is the same—involvement. Only by involvement of and with all recipients of care and all who need care can we actually accomplish comprehensive care. And adequate involvement cannot be achieved by any system, health or otherwise, that fails to see its relationship to the totality of its community —the spiritual, financial, and social elements as well as the health elements."

attention doctors--

When you guard the health of your funds by investing them where they are safe and accessible, you're practicing preventive medicine against inflation. And, funds grow at a gratifying rate through DAILY compounding of dividends.

5.23%
ON PASSBOOK ACCOUNTS
Effective Annual Yield
Compounded & Computed DAILY

Guaranteed Protection
Accounts insured up to $20,000 by the Maryland Savings Share Insurance Corp.

SECURITY
Savings & Loan
(a stock corporation) Organized 1895

24 E. Fayette at St. Paul Street Phone: 727-4415

T. ROWE PRICE GROWTH STOCK FUND, INC.



BALTIMORE, MARYLAND

A stock portfolio carefully selected for possible growth of principal and income.

NO SALES CHARGE
NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

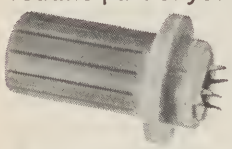
T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.

- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE EVANGELICAL PRESS
THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



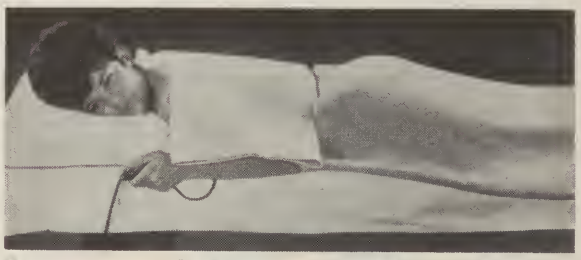
Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.
Miss Gladys Deeds
Manager
213 West Saratoga St. 727-7011

Now When You Recommend Moist Heat,



Recommend Automatic Moist Heat.

Until now, application of moist heat required boiling water, hot towels, and somebody to apply them. The Battle Creek THERMOPHORE changes all that. It provides instant and automatic moist heat, intensely hot, deeply penetrating.
The patient simply plugs it into an outlet. This unique hot fomentation pad then generates its own moisture from the air. Intensely hot moist heat is constantly maintained, and evenly distributed throughout the pad. No water is needed, no filling or emptying is required.
Large 13" x 27" pad covers back, or chest and abdomen, or both legs. Safety thermostat turns it off automatically, prevents overheating.
Price is **$35.00.** Also available in medium size 13 x 13 **$25.00.**
Phone for Free Descriptive Literature, or See It At . .

THERAPEUTIC APPLIANCES, INC.
JULES MORSTEIN
1114 Light St. Phone 752-6996
Baltimore, Md. 21230

When it's more than a bad cold



your patient can feel better while he's getting better

Achrocidin®

Tetracycline HCl—Antihistamine—Analgesic Compound

Each tablet contains: ACHROMYCIN® Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Caffeine 30 mg.; Salicylamide 150 mg.; Chlorothen citrate 25 mg.

In tetracycline-sensitive bacterial infection complicating respiratory allergy, ACHROCIDIN brings the treatment together in a single prescription—prompt relief of headache and congestion together with effective control of the organisms frequently responsible for complications leading to prolonged disability in the susceptible patient.

For children and elderly patients you may prefer caffeine-free ACHROCIDIN Syrup. Each 5 cc contains: ACHROMYCIN (Tetracycline) equivalent to Tetracycline HCl 125 mg.; Phenacetin 120 mg.; Salicylamide 150 mg.; Ascorbic Acid (C) 25 mg.; Pyrilamine Maleate 15 mg.

Contraindications: Hypersensitivity to any component.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Drowsiness, anorexia, slight gastric distress can occur. In excessive drowsiness, consider longer dosage intervals. Persons on full dosage should not operate vehicles. Nonsusceptible organisms may overgrow; treat superinfection appropriately. Treat beta-hemolytic streptococcal infections at least 10 days to help prevent rheumatic fever or acute glomerulonephritis. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Adverse Reactions: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity* reactions—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

348-8


SPAIN
ARIZONA
FLORIDA
ENGLAND

Our travel-pak for summer cold and allergy sufferers.

lovahistine LP can speed your atients on their way, by providing rompt and continuous relief from the ymptoms of summer colds and llergies. These continuous-release ablets contain a vasoconstrictor-ntihistamine formulation that goes to vork rapidly and lasts for hours. ven when nasal congestion is caused y repeated allergic episodes, the onvenient twice-a-day dosage of lovahistine LP makes it easy for most patients to enjoy relief all day and all night. When symptoms are severe, a third dose of one or two tablets may be safely given. Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result.

PITMAN-MOORE Division of The Dow Chemical Company, Indianapolis, Indiana.

Novahistine® LP decongestant

(Each tablet contains 25 mg. of phenylephrine hydrochloride and 4 mg. of chlorpheniramine maleate.)

DOW

For elderly patients
in need of a mild tranquilizer
consider **Tybatran**®
brand of tybamate

(When you consult
the Prescribing Information
you may agree
it makes good sense)



PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

HOOD CONVALESCENT HOME

"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF

CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED

National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM

Certificate Holder—Baltimore County
Fire Prevention Bureau Award

LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800

5313 EDMONDSON AVE.

The World's Best $2000
Car stops
with disc brakes
straight, quick & sure!



It's yours for only $44 a month

Front disc brakes for safety! Fully independent rear suspension for comfort. Bucket seats and dozens of other extras, too.

DATSUN / 2

All colors and models in stock for immediate delivery!

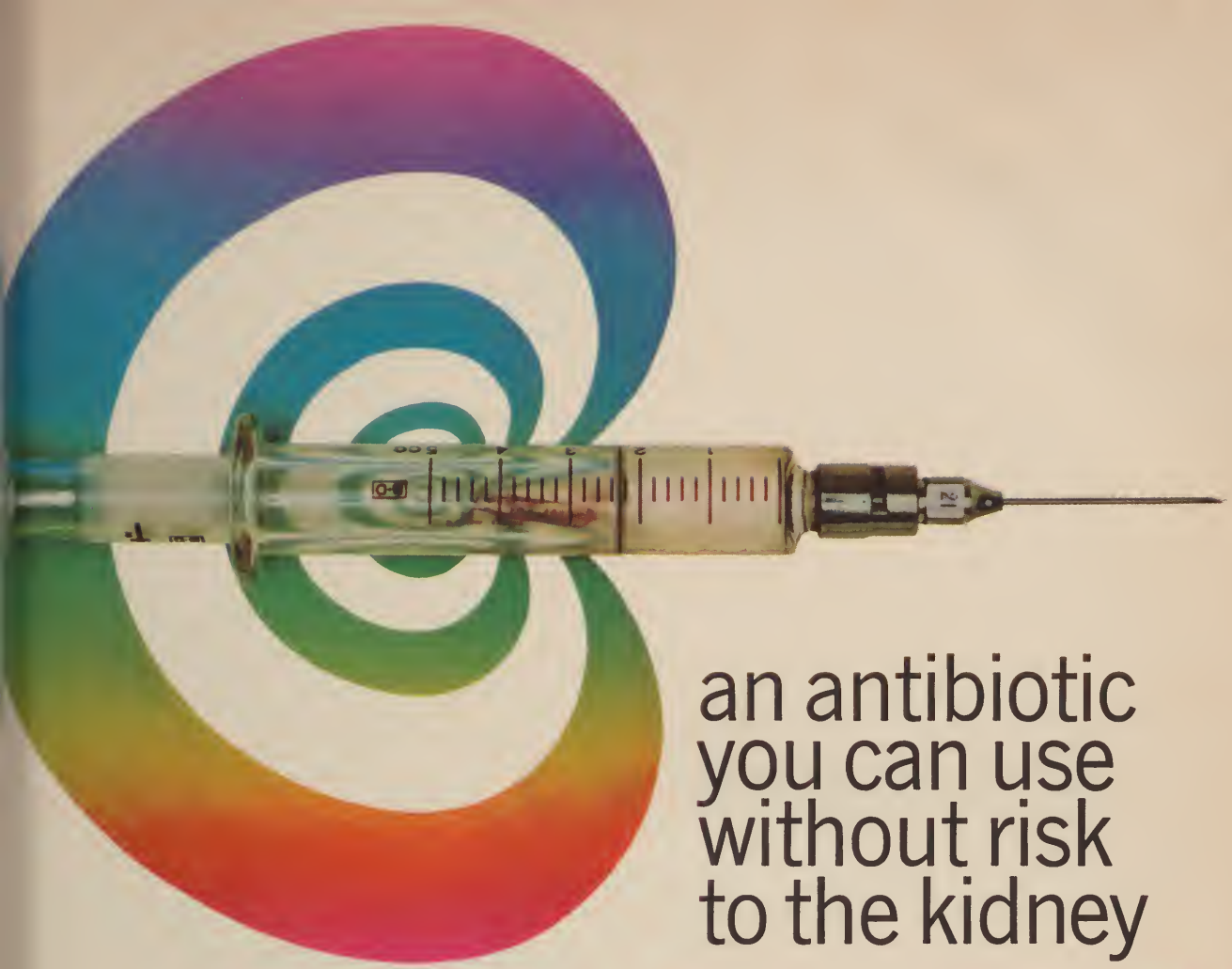
TOWN & COUNTRY MOTORS

8021 Harford Rd. Baltimore, Md. 21234

665-7500

—The lowest priced tetracycline—nystatin combination available—





an antibiotic you can use without risk to the kidney

Polycillin-N®

(sodium ampicillin)

the penicillin you use like a broad-spectrum antibiotic

PRESCRIBING INFORMATION. 11—1/2/69. For complete information consult Official Package Circular.

Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles. **A.H.F.S. Category 8:12.16**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201



Indications: For the treatment of trichomoniasis in both male and female patients and the sexual partners of patients with a recurrence of the infection provided trichomonads have been demonstrated by wet smear or culture.
Contraindications: Evidence of or a history of blood dyscrasia, in patients with active organic disease of the central nervous system, and the first trimester of pregnancy.
Warnings: Use with discretion during the second and third trimesters of pregnancy and restrict to patients not cured by topical measures. Flagyl (metronidazole) is secreted in the breast milk of nursing mothers; it is not known whether this can be injurious to the newborn.
Precautions: Mild leukopenia has been reported during Flagyl use; total and differential leukocyte counts are recommended before and after treatment with the drug, especially if a second course is necessary. Avoid alcoholic beverages during Flagyl therapy because abdominal cramps, vomiting and flushing may occur. Discontinue Flagyl promptly if abnormal neurologic signs occur. There is no accepted proof that Flagyl is effective against other organisms and it should not be used in the treatment of other conditions. Exacerbation of moniliasis may occur.
Adverse Reactions: Nausea, headache, anorexia, vomiting, diarrhea, epigastric distress, abdominal cramping, constipation, a metallic, sharp and unpleasant taste, furry or sore tongue, glossitis and stomatitis possibly associated with a sudden overgrowth of *Monilia,* exacerbation of vaginal moniliasis, an occasional reversible moderate leukopenia, dizziness, vertigo, drowsiness, incoordination and ataxia, numbness or paresthesia of an extremity, fleeting joint pains, confusion, irritability, depression, insomnia, mild erythematous eruptions, "weak-

Flagyl®
brand of
metronidazole

simplifies vaginitis therapy

The effectiveness of Flagyl in *Trichomonas vaginalis* vaginitis has been so constant that use of less effective agents would seem to invite unnecessary failures. ▪ The simplicity, completeness and persistence of cures with Flagyl qualify it as the logical first therapeutic choice in trichomonal infections.

simple Ten-day treatment with Flagyl oral tablets has replaced a multitude of untidy douches, powders, creams and jellies.

complete Flagyl is the only medication available that is able to reach all the crypts, glands and cavities of the female urogenital system as well as reservoirs of reinfection in male trichomonas carriers.

lasting Flagyl eradicates resistant, deep-seated invasions of *Trichomonas vaginalis* and consistently produces cure rates above 90 per cent and often as high as 100 per cent in large series of patients. When the diagnosis is positive, Flagyl is positive.

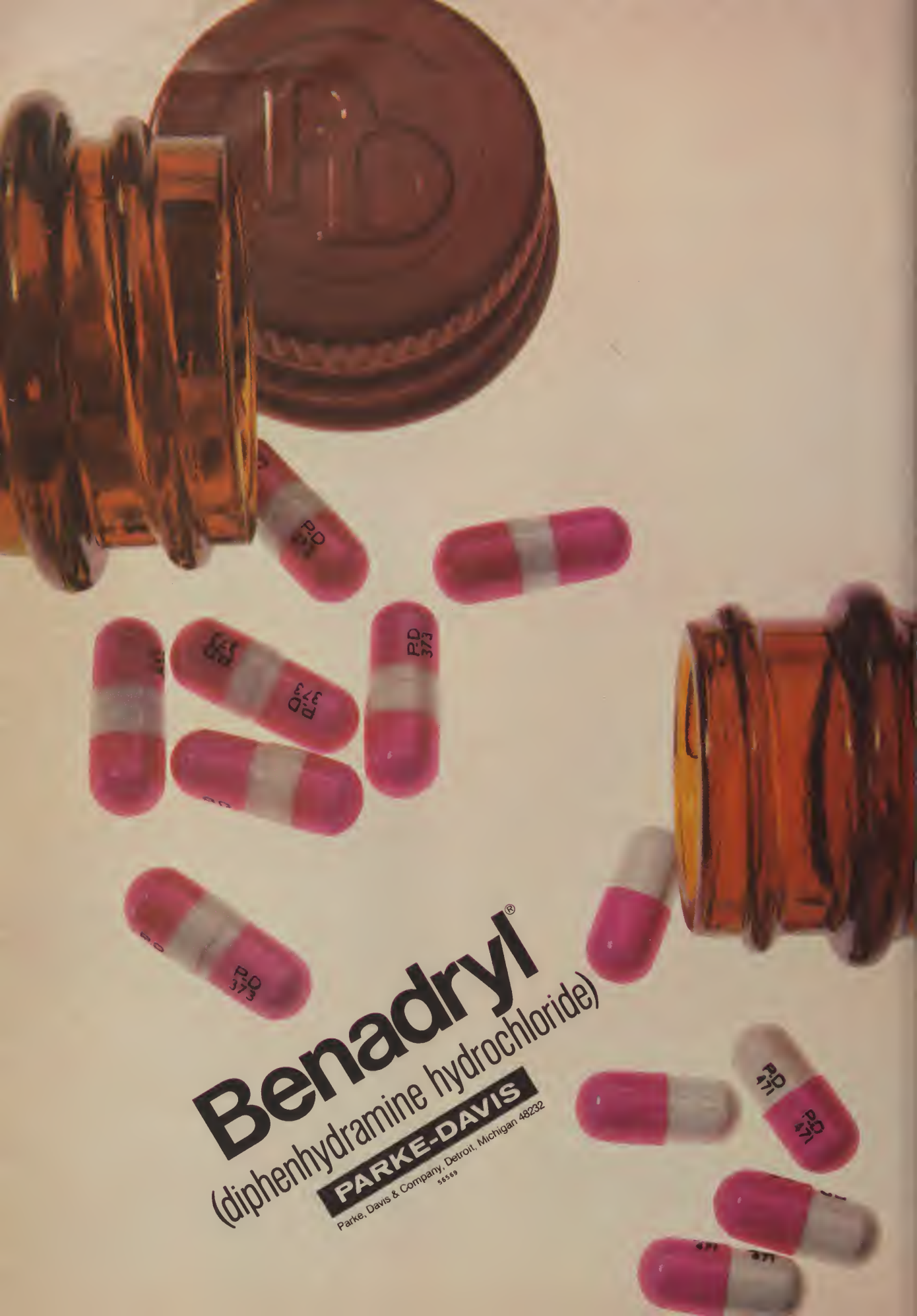
ness," urticaria, flushing, dryness of the mouth, vagina or vulva, vaginal burning, pruritus, dysuria, cystitis, a sense of pelvic pressure, dyspareunia, fever, polyuria, incontinence, decrease of libido, nasal congestion, proctitis, pyuria and darkened urine have occurred in patients receiving the drug. Patients receiving Flagyl may experience abdominal distress, nausea, vomiting or headache if alcoholic beverages are consumed. The taste of alcoholic beverages may also be modified.

Dosage and Administration: In the Female. One 250-mg. tablet orally three times daily for ten days. Courses may be repeated if required in especially stubborn cases; in such patients an interval of four to six weeks between courses and total and differential leukocyte counts before, during and after treatment are recommended. Vaginal inserts of 500 mg. are available for use, particularly in stubborn cases. *When the vaginal inserts are used,* one 500-mg. insert is placed high in the vaginal vault each day for ten days and the *oral dosage is reduced to two 250-mg. tablets daily during the ten-day course of treatment.* Do not use the vaginal inserts as the *sole* form of therapy. *In the Male.* Prescribe Flagyl only when trichomonads are demonstrated in the urogenital tract, one 250-mg. tablet two times daily for ten days. Flagyl should be taken by both partners over the same ten-day period when it is prescribed for the male in conjunction with the treatment of his female partner.

Dosage Forms: Oral tablets .....250 mg.
Vaginal Inserts ...500 mg.

G. D. SEARLE & CO.
Research in the Service of Medicine

941


P.D
373
Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
55569

Letters to the Editor:

In Answer to the June Editorial

Dear Sir:

I read with interest the article by Dr. John F. Schaefer in your June 1969 issue concerning the problems surrounding the services of out of state laboratories.

Let me say from the start that I believe that the tone of the article is unfortunate. Little is achieved by getting mad. A case is generally weakened by the loss of emotional control.

I agree with much that Dr. Schaefer has to say. However, there are some weak points. Although the pathologist technically qualifies as a consultant, he rarely functions as such when his laboratory performs routine tests. He does not see the patient; he does not get the history; he seldom performs the test. Even if he sees the test results he does not interpret them in the light of the over-all picture. This interpretation is left up to the physician who orders the test in most cases. Therefore, in many instances the pathologist functions as a technician who presents the responsible physician with helpful data, just as a nurse who takes a bloodpressure or a temperature. Many people could say with some foundation that the function of a medical laboratory is more technical than consulting.

The article fails to mention that there is a real problem in this area for the practicing physician. My private-pathologist laboratory is not as convenient as Dr. Schaefer makes me believe his is. My patients often have to wait; they have to make a special trip to get there; they have a terrible time finding a parking place. I do use this laboratory, don't misunderstand me, and many others with me do. When I send a patient over for a few simple tests, say a bloodsugar, BUN, cholesterol, uric acid, and a bloodcount, my patient ends up with a $25.00 bill. Some of my colleagues in town obtain twice as many tests for half the money from the out-of-state laboratory. Their tests are generally reliable since they use a good, honest, well-qualified laboratory. All this is hard to explain to a patient. Is a one-dollar-bloodsugar less good than a five-dollar-one? And don't forget the time a patient spends waiting in, and going to the laboratory.

The cost of medical care is tremendous. Much of this is justified. We have an obligation to our patients to eliminate excessive cost. If a commercial laboratory can do the same thing for less than half the cost we should at least stop and think. Are we defending the status quo? Or should we tell our pathologist-friends to get up and do something about all this? Shouldn't they modernize their equipment, shouldn't they pool their resources, shouldn't they eliminate small volume, inefficient, slow methods? Let's at least admit that some of the modern, large volume, commercial laboratories have a point. Let's try doing something about this instead of getting mad.

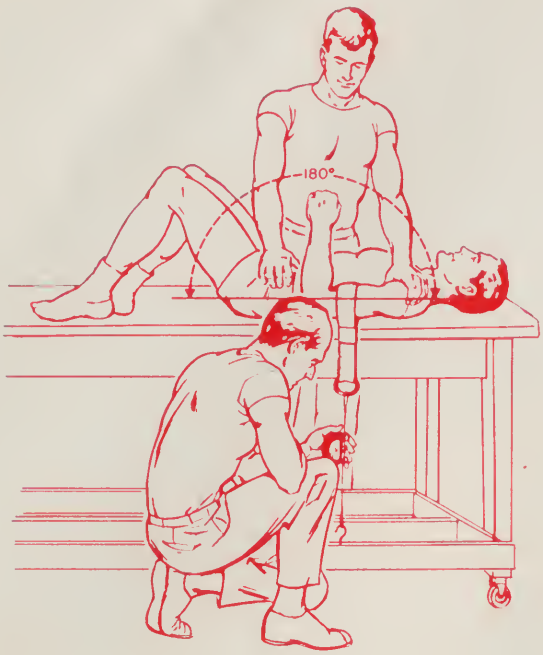
I certainly agree that some of the out-of-state laboratories seem to use unethical methods of advertising, that some of them are unreliable, that many of them do not offer all the benefits of the local pathologist run laboratories. However, I do feel that we are facing a problem here that needs a solution. This solution is not achieved by the type of article that Dr. Schaefer writes.

I am writing this letter because I am concerned. I am not related to any laboratory. I feel that I have an obligation to my patients to offer them the best possible care utilizing his money prudently.

I should appreciate some official action by the Maryland state medical society that indicates concern for the patient, for his money, and for the practicing physician. I read in Dr. Schaefer's article concern for his pathologist-friends only.

Sincerely yours,
Peter F. Verkouw, MD
Annapolis

(Dr. Verkouw has overlooked the very active part the Faculty has played in establishing the Commission on Medical Discipline, which has a specific section dealing with "exploitation of the patient." He probably did not read the letter sent to all members under date of April 30, 1969, by the Faculty President which clearly spells out what is ethical and what is unethical in the billing of patients by physicians for laboratory services. There are probably just as many individual physicians who disagree with Dr. Verkouw's viewpoint as there are with mine. But that is what makes and has made American medicine great.—JFS)



At left: This is a test for shoulder flexion—the mean strength is obtained by flexing the biceps muscle in the shoulder adduction movement.

At right: The test for measuring back lift is another test of strength. The subject bends slightly forward, with knees straight, and grasps the bar near the ends. The grip is mixed, one hand forward and one hand backward. The subject is asked to lift straight up. The strength in poundage is measured by the dial.



The following papers were presented at the Second Annual Medical Aspects of Sports Seminar, held August 1968 at the Catonsville Community College, Catonsville, Maryland. The Seminar was sponsored by the Medical and Chirurgical Faculty of the State of Maryland and the Division of Health, Physical Education and Recreation of Catonsville Community College.



Measurement of Physical Fitness

Introduction to a Dilemma

Even a cursory survey of both professional and lay literature will evidence an overwhelming interest in "physical fitness." Indeed, the interest in and concern for fitness prompted the late President Eisenhower to create the Council on Youth Fitness now designated as the President's Council on Physical Fitness. Thus, in addition to the pleas of physical educators and physicians, even governmental agencies are urging both children and adults to achieve and maintain physical fitness.

EDWARD N. NORRIS, EdD, RPT
Associate Professor of Health and Physical Education
West Chester State College
West Chester, Pennsylvania

Paradoxical as it may seem, one is unable to find anywhere a universally accepted definition of "physical fitness" or a specific description of its desired state. Although some writers offer definitions, they are invariably vague, too broad, too general, or too simple for infallible application. Examples of such attempts at definition are: *"Physical fitness* is a capacity for sustained physical activity"[1], and "Physical fitness may be defined as the capacity to do physical work and to recover quickly and completely from doing this work."[2] If one attempts to use such definitions in clinical work, including physical education and coaching, or in laboratory research, the lack of precision becomes readily apparent.

The problem of definition results from the generic, complex and relative character of the term "fitness." This is evident in the statement by the Joint Committee of the American Medical Association and the American Association for Health, Physical Education and Recreation that

> **"Fitness for effective living has many interdependent components involving intellectual and emotional, as well as physical factors. These differ in relative importance from one period of life to another depending upon varying individual roles and responsibilities. But in every part of life, each of these factors is significant."[3]**

Thus, it is precisely because of these "interdependent components" that no *one* definition is universally accepted. Indeed, it is entirely possible that "physical fitness" may never be defined precisely as a single entity, the plea for arbitrary definitions notwithstanding.[4]

The dilemma in any attempt to measure "physical fitness" is now obvious: How can we evaluate or measure that which we cannot even define with precision? In this context one writer has stated:

> **"Until the time comes when the definition of fitness is agreed upon and we have the instruments for objectively measuring it, there will continue to be confusion as to what is the best evaluative approach to this problem."[5]**

Components and Levels of Physical Fitness

The fact that there is no universally accepted definition of "physical fitness" and that many of the definitions that have been proposed lack specificity, does not preclude the possibility and the value of factoring out selected components of fitness for detailed description and evaluation. It seems that many authorities have done exactly this as an alternative to the lack of definition. Indeed, there are almost as many ways of categorizing the components of physical fitness as there are exercise physiologists.

At this point in time, I arbitrarily select the components of fitness as outlined by de Vries[4] as being appropriate for discussion if not omnipotent and eternal in character. This outstanding physiologist views physical fitness as having two major components: (1) motor fitness; and (2) physical working capacity. He identifies motor fitness, which has been a major concern of the physical educator as consisting of strength, speed, agility, endurance, power, coordination, balance, flexibility, and body control. Physical Working Capacity (PWC), which has been a major concern of the medical profession includes such elements as cardiovascular function, respiratory function, muscular efficiency, strength, muscular endurance and obesity. Of more than incidental interest is de Vries suggestion that the PWC concept should receive wider consideration in the physical education profession.[4]

Accepting these components of physical fitness, the problem then becomes one of identifying the degree to which each is desirable. For example, what is an optimum level of strength? What is an acceptable criterion of adequate cardiovascular function? It is immediately obvious that these are not simple questions as the requirements will vary with the particular individual under consideration and with the specific task he is expected to complete. Thus, one writer has been prompted to state that "at present, fitness has established meaning only in terms of the task to be accomplished."[6] This point of view enjoys wide acceptance in the literature. Certainly no one will disagree with the idea that a professional athlete probably requires greater strength than a bank teller or that a gymnast needs a greater upper extremity strength than a distance runner. Thus, the relative importance of each component, the level to which each component is to be developed, and indeed the anatomic area to be developed depends wholly on the total life situation of the specific individual being evaluated. This leads to the simple, although practical conclusion, that, although many of the aspects of fitness can be measured in highly objective terms, no one can write a blanket prescription for the optimum level to which each should be developed.

Subjective Evaluation of Physical Fitness

At this juncture, prior to reviewing some of the objective methods of evaluating fitness, it is of some value to be reminded that the subjective judgment of an expert is not without validity. Certainly a swimming coach can factor out some components of fitness such as skill, strength, and endurance for subjective evaluation and make some assessment of the adequacy of each. In like fashion, a football or basketball coach can certainly make some equally valid—although subjective—judgments about the fitness components of the members of his squad. After all, the proof is in the pudding: the actual performance in the task speaks very profoundly about the fitness for that task.

Subjective judgment also has value in the field of medicine. Certainly it can be agreed that the physician should also evaluate fitness for the task, ie, the daily requirements of the patient's total life situation. Even though the physician cannot observe directly the daily activities of his patients in the same manner that a coach can observe the performance of his athletes, he can ask questions relative to performance and make some judgments accordingly. Some appropriate questions concerning his patients have been suggested:

> **"What are his current activities? What were his activities in the past? How do they differ from his present ones? Does he have any symptoms suggesting untoward reactions to exercise? How long does it take him to recover from strenuous exercise?"[7]**

Although subjective evaluations are frowned upon in the research laboratory, until more adequate and easily administered objective techniques become available, subjective judgments will continue to be important in the "field."

Objective Measures of Motor Fitness

It is beyond the scope of this paper to present a comprehensive survey of all of the objective techniques available to measure the components of motor fitness as previously outlined. Concerning these varied aspects, de Vries himself has stated:

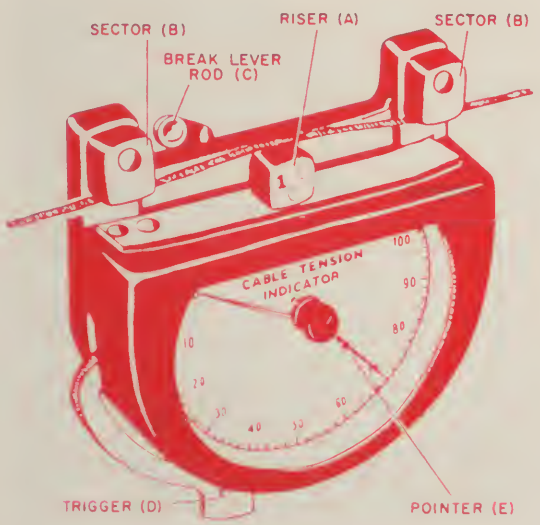
> **"The elements of motor fitness are so many, however, and some are so difficult to define, that each motor performance test battery must be considered a compromise between the ideal of measuring all identifiable elements and the practical need to choose a number of represent-**

ative elements, which allows measurement in reasonable amounts of time."[4]

Quite arbitrarily, therefore, the writer has elected to merely highlight *some* of the techniques to evaluate *some* of the components of motor fitness. This approach seems justified in that there are many fine textbooks and voluminous periodical literature available for the interested reader. More important, however, it is justified so that more time and attention can be devoted to the PWC concept which is probably of greater significance to any overall fitness appraisal.

Of all of the elements of motor fitness, muscular strength and endurance are perhaps of overriding importance. Although strength and endurance are probably related in ways not, as yet, fully understood, one can differentiate between them by definition and therefore can evaluate them separately. Strength can be defined as the amount of rotary force a muscle or a muscle group can produce about a joint in a single maximal effort. Muscular endurance, on the other hand, is the ability of a muscle or a muscle group to produce repetitive or sustained submaximal contractions. Within this context, therefore, numbers of chins or numbers of push-ups are not measures of strength. The fact that at least one push-up or chin can be accomplished is an index of pass or fail strength, but two or more become an index of muscular endurance.

If one wishes to be more precise in the evaluation of muscular strength one can perform a series of single contractions interspersed with significant rest periods against some form of weight or resistance. Maximal isotonic strength is identified when the maximum weight that can be lifted in a single effort is reached. Repeated single contractions can be eliminated by using one of several types of dynamometers or by use of a cable tensiometer which permits direct reading of isometric strength in force units.



Muscular endurance can be measured with some precision by counting the number of chins or push-ups or by noting the time one can perform a bent arm hang, for example. For greater precision, however, one might count the number of contractions that can be performed against some specified external force or resistance at some predetermined cadence.

Another element of motor fitness, power, is sometimes confused with strength. The difference is that power incorporates a time element, whereas strength is based upon a single maximal effort regardless of speed or time spent in the application of that effort. Power consists of both strength and speed and is frequently expressed in horsepower. One can easily see, therefore, why the standing broad jump, jump and reach tests and putting the shot are viewed as measures of power.

Flexibility is a rather simple concept that lends itself to easy measurement. If one is not satisfied with subjective judgment which, in estimating flexibility, is rather good, one can use the well-known goniometer to quantity joint angles and joint movement. A more recent device, the Leighton Flexometer, is also available for measuring joint range of movement or flexibility.



Flexibility Tests

Above is the Leighton Flexometer. This is an instrument used for objectively measuring the flexibility of the joint movements. The instrument has a weighted 360° dial and a weighted pointer. The dial and the pointer operate free and independently; the movement of each is controlled by gravity. The instrument will record movement while in any position off the horizontal.

At left is the cable tensiometer. This small compact unit was originally designed to test the tension of aircraft control cables. Cable tension is determined by measuring the force applied to a riser and causing an offset in a cable stretched taut between two sectors. The tension is then converted into pounds on a calibration chart supplied with the instrument. The test is used for testing the strength and flexibility in various muscle groups.

Because they probably rely on more exquisite integration within the nervous system, speed, agility, coordination and balance are more complex concepts than strength, endurance and flexibility. There does not seem to be any one test or technique that can be used to assess the basic quality of any one of these. Although one may describe a subject as having good speed, good agility, good coordination and good balance, it is doubtful that these are truly general qualities. Rather, they are probably highly task-orientated and should be measured, therefore, only in relationship to a specific activity. de Vries [4] reminds us that, in the case of speed for example, there is essentially no correlation between speed of movement of different limbs, or between different movements of the same limb. Suffice it is to say that, as yet, we do not have sufficient knowledge of speed, agility, coordination or balance to design any test that can measure these attributes in a general way.

Thy Physical Working Capacity

Probably the most significant and fundamental concept in measuring physical fitness is the physical working capacity (PWC). Defined ". . . as the maximum level of metabolism (work) of which an individual is capable," [4] it provides an opportunity to evaluate a complex chain of physiological events in a single score or index. To measure lung vital capacity, total hemoglobin, maximal cardiac output, or height and weight provides only a partial picture of physiological capability. The total picture would be an expression of the actual physical work performed or the ability to take in and use oxygen upon which the ability to perform work is dependent.

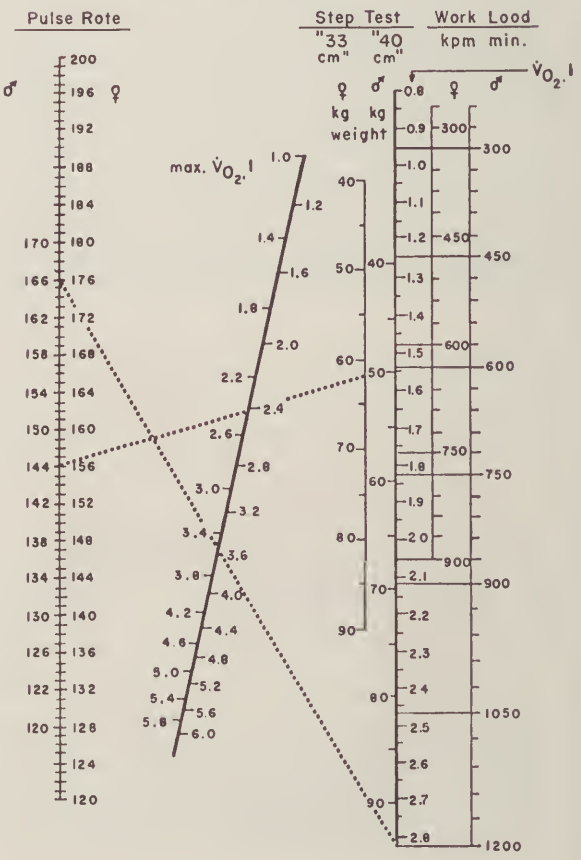
Although there are several ways in which the overall oxygen transport function can be expressed, the maximal oxygen uptake is most widely accepted. Indeed, so many writers [8] have concluded that the maximal oxygen uptake is the best single indicator of cardiovascular or circulo-respiratory fitness that it becomes a validating criterion for other tests of physical working capacity.

Unfortunately, the actual measurement of maximal oxygen uptake is a complicated and time-consuming procedure requiring rather expensive and sophisticated equipment. Further, the procedure also requires an all-out effort on the part of the subject which may not always be desirable if indeed medically permissible. It is concluded, therefore, that the actual measurement of maximal oxygen uptake is a laboratory procedure and not practical in the general practice of physical education or medicine. However, what is not always practical to measure directly might be predicted from other data. As might be expected, there have been numerous simplified and submaximal procedures proposed for predicting maximal oxygen uptake. Two of these seem worthy of further consideration.

In 1954, Åstrand and Rhyming [8] proposed a nomogram for the prediction of maximal oxygen uptake from pulse rate data obtained during submaximal work. Since that time, their method has enjoyed wide acceptance for implementation on a treadmill, a bicycle ergometer or via bench stepping. Recent studies in our own laboratory have attested to the usefulness of the Åstrand-Rhyming prediction and its significant relationship to other indices of circulo-respiratory fitness and to the actual physical work performed.[9] Although a few may have a treadmill or bicycle ergometer available, it seems that bench stepping might be the preferred exercise medium for general physical education and general medicine.

The bench-stepping procedure [10] for the Åstrand-Rhyming prediction requires a 40 cm bench for men and a 33 cm bench for women. Stepping at the rate of 22.5 rises on to the bench per minute the exercise is performed for five or six minutes to be assured of a steady state. Pulse rates are taken at the end of each minute and the average of the last two minutes is calculated. Applying the pulse rate and the subject's body weight to the nomogram, one reads directly the predicted maximal oxygen uptake.

ASTRAND'S NOMOGRAM FOR PREDICTION OF MAXIMAL OXYGEN UPTAKE



Although a relatively simple procedure the use of the Åstrand-Rhyming nomogram for prediction of maximal oxygen uptake has one serious drawback: It is impractical, if not impossible, to test large numbers of subjects as may be desirable in physical education. Thus, the recent proposal of a 12-minute field test by Cooper in his book *Aerobics*[11] seems to merit detailed consideration. Originally using 115 U.S. Air Force male officers, Cooper found a correlation of 0.897 between the distance they could run-walk in 12 minutes and their oxygen consumption.[12] Thus, he concluded that the 12-minute test provided a good estimate of maximal oxygen consumption assuming the subjects are well-motivated.[12]

Cooper's 12-minute test has much to recommend it: It uses a well-known exercise, is adaptable for large group testing, requires little if any training to administer, and requires only a measured track, a stop watch and a whistle as necessary equipment. More important, however, is the fact that the entire Aerobic concept as advanced by Cooper is based upon the maximal oxygen uptake as an index of fitness. Not only does Cooper provide a simple and effective test based upon sound scientific principles, but he, also, for the first time, advances a pharmacopeia of exercise so that dosage can be regulated. Professionals in the fields of physical education and medicine should not be misled by the popular appeal of the book *Aerobics* as Cooper's credentials are impeccable. It appears that the 12-minute run-walk test may become a standard procedure to evaluate the type of physical fitness that is most important: the ability to take in and use oxygen.

Conclusion

Although physical fitness is one of our greatest human resources, its practical measurement presents a complex problem. In that there is no one universally accepted definition of physical fitness, there can be no one universally accepted test for measuring it. One must conclude, therefore, that each evaluator must identify the components of fitness that seem most important in his frame of reference and then select appropriate tests. There is, however, one component that seems basic to all human activity and perhaps to longevity as well: the ability to take in and use oxygen. Perhaps all fitness testing should start with the evaluation of maximal oxygen uptake by one of the several methods that have been proposed.

REFERENCES

1. Willgoose, Carl E.: *Evaluation in Health Education and Physical Education* (New York: McGraw-Hill Book Co., Inc., 1961), p. 105.
2. Cumming, G. R.: "Current Levels of Fitness," *Proceedings of the International Symposium on Physical Activity and Cardiovascular Health, Can. Med. Assn. J.*, **LXXXXVI** (March 25, 1967), 868.
3. Statement of the Joint Committee of the American Medical Association and the American Association for Health, Physical Education and Recreation, "Exercise and Fitness," *J. Am. Assn. Health, Phys. Educ. and Rec.*, **XXXV** (May, 1964), 42.
4. de Vries, Herbert A.: *Physiology of Exercise for Physical Education and Athletics* (Dubuque, Iowa: Wm. C. Brown, Co. Publishers, 1966), p. 204, 213, 218-221.
5. Mathews, Donald K.: *Measurement in Physical Education* (Philadelphia: W. B. Saunders Company, 1968), p. 59.
6. Darling, Robert C.: "The Significance of Physical Fitness," *Arch. Phys. Med.*, **XXVIII** (March, 1947), 140.
7. Committee on Exercise and Physical Fitness, "Is Your Patient Fit?" *JAMA*, **CCI** (July 10, 1967), 117.
8. Anderson, Lange K.: *Health and Fitness in the Modern World*, (Chapter 42, "Physiological Working Capacity"), (New York: The Athletic Institute, 1961), p. 366; Bruno Balke, *A Simple Field Test for the Assessment of Physical Fitness*, Civil Aeromedical Research Institute, Bulletin 63-6 (Washington: Government Printing Office, 1963), p. 8; Bruno Balke and Ray W. Ware, "An Experimental Study of 'Physical Fitness' of Air Force Personnel," *U. S. Armed Forces Med. J.*, **X** (June, 1959), 676; R. G. Glassford *et al.*, "Comparison of Maximal Oxygen Uptake Values Determined by Predicted and Actual Methods," *J. Appl. Physiol.*, **XX** (May, 1965), 509; and P. O. Astrand and Irma Rhyming, "A Nomogram for Calculation of Aerobic Capacity (Physical Fitness) from Pulse Rate During Submaximal Work," *J. Appl. Physiol.*, **VII** (September, 1954), 218.
9. Norris, Edward Nelson: "An Investigation of a Test of Work Capacity and Its Relationship to Circulo-Respiratory Fitness," (unpublished Doctor's dissertation Temple University, Philadelphia 1968), p. 127.
10. Consolozio, C. Frank: Johnson, Robert E. and Pecora, Louis J.: *Physiological Measurements of Metabolic Functions in Man* (New York: McGraw-Hill Book Company, Inc., 1963), p. 392.
11. Cooper, Kenneth H.: *Aerobics* (New York: Bantam Books, 1968), pp. 182.
12. Cooper, Kenneth H.: "A Means of Assessing Maximal Oxygen Intake," *JAMA*, **CCIII** (January 15, 1968), pp. 135-138.

TOTAL BODY WATER

Intracellular		41%
Extracellular		
Plasma	4%	
Interstitial	15%	
Other	5%	
Total		24%

WATER BALANCE

Intake:		
Food	1200 cc	
Metabolic	200 cc	
Fluid	1000 cc	
Total		2400 cc
Output:		
Urine	1500 cc	
Stool	150 cc	
Respiration	350 cc	
Insensible	500 cc	
Total		2500 cc

ENERGY REQUIREMENT

Basal Metabolism	1500 C	
Non-Labor Activity	500 C	
Total		2000 C
Work	600 C to 3000 C	
Total	2600 C to 5000 C	

Weight control is a problem of substantial importance to all athletes and their coaches. In certain sports, such as wrestling, the attainment of a low weight can represent a disproportionate advantage. I hope to demonstrate that the proper weight loss or gain, to reach an optimum (rather than the minimum or maximum) is beneficial to the athlete in any sport including wrestling and football.

Weight Control in Athletics

HERMAN C. MAGANZINI, MD, FACP
Team Physician
Richard Montgomery High School
Rockville, Maryland

It has been shown experimentally that obese individuals expend more energy for each unit of work performed, when compared to normal controls. There is also an increase in the "relative intensity" of energy expenditure for moderate work, ie, the blood pressure, heart rate, pulmonary ventilation, and alveolar-arteriolar FO_2 difference is increased in these individuals per unit of work.[1] In addition, it has been shown that obese individuals adapt poorly to heat and may not acclimatize at all under those same conditions of fluid and salt intake, plus exercise in the heat, which would produce this in those of normal weight.

In essence, the athlete best able to perform his given task in any sport, would be one of the proper weight and muscular development for his height and body build, given of course the necessary conditioning, coordination and skills.

Body Composition

When we speak of body weight we ordinarily give little consideration to what this represents in detail. The "scale weight" is really a composite of all those parts of the body which contribute to the body mass, namely fat, muscle, water, bone and other tissues. The weight of bone and other fixed tissue cannot readily be changed and, therefore, are not pertinent to the present discussion. The various proportions of fat, muscle, and water in an individual *can* be modified and are important to his functional capacity.

Body Water

In males 65% of the body weight is water. The specific percentage depends on the lean body mass, for adipose tissue (fat) contains only 20% water, while muscle contains 75% water. Obviously the more muscular individual would have a greater proportion of body water when compared to the fat one. Most of this water is inside of the body cells (intracellular) and under most considerations remains relatively stable at approximately 41% of the body weight. Of the other 24% (extra-cellular fluid), 4% is in the plasma (the liquid part of the blood), 15% is in the interstitial space (those minute crevices between cells and tissue planes), and 5% in the other areas (bone, water, eye fluid, etc.). Under ordinary circumstances water balance is maintained by the intake of approximately 1200 cc as the liquid part of food, 300 cc produced by the metabolism of this food to carbon dioxide and water, and 1000 cc in the form of actual liquid drinks. Of this ingested amount, approximately 1500 cc is excreted as urine, with 150 cc in the

stool, while 350 cc is lost in the expired air, and 500 cc by "insensible perspiration". This is not actual *sweat* as we usually appreciate it but minute quantities lost constantly from the skin and not really felt by us. This is a total output balancing the intake of approximately 2500 cc. Most increases in intake are balanced by automatic physiologic mechanisms which increase the output of urine. Marked increases in water loss, such as visible sweat, can only be balanced by voluntary increases in the intake of fluid and salt.[2]

Fat (Adipose Tissue)

Calories ingested in excess of daily needs are stored as fat. Those calories greater than the energy expended in heat production or in work are so stored. The caloric value of human adipose tissue (fat) has been calculated at approximately 3500 calories per pound, ie, one pound of fat will yield 3500 calories when metabolized.[3] This means that in order to lose one pound of fat, sufficient energy must be expended to utilize 3500 calories more than consumed as food or drink during the same time interval. Likewise, in order to gain one pound of fat an individual must consume food with a caloric value of 3500 calories greater than that used.

Muscle

Muscle is that tissue which actually performs the work of exercise and of productive work. All athletic training is aimed towards developing many or specific groups of muscle peculiar to the sport in question. This is in addition of course to the general cardiovascular adaptations of conditioning which are essential and common to well trained athletes in any sport.

Weight Change

Increase or decrease in weight can be reasonably accomplished only by manipulating the variables of water and fat *primarily*, and less so that of muscle mass. Loss of muscle weight occurs only in malnutrition or in the changes which occur when the highly developed muscular individual becomes less well developed and untrained as he stops continuous exercise or work. Even then the total body weight may not necessarily decrease but frequently remains stable as the ratio of fat to muscle changes. Some part of the weight which previously had been muscle is now fat. Well trained and muscular athletes especially in certain sports such as football and the shot-putter in track, etc. tend to have large well developed muscle masses. We are all aware however of the 225 pound, 6 foot 2 inch college lineman who grows to a 225 pound flabby, desk worker some years later. What happened to him? His height and weight are the same but now the muscle mass previously developed by constant exercise and work is gone. This muscle weight loss has been masked however by a weight gain of fat. His non-playing ideal weight as compared to his ideal weight while muscularly active is probably closer to 200 pounds or less.

Gaining weight by building muscle on the other hand requires continuous exercise and work to develop those muscles in question. This is accomplished by weight lifting, running, etc. but even then there is frequently little weight gain but rather a replacement of the lost weight of fat by increasing muscle mass.

The other two variables of total body weight namely water and fat, are much more easily manipulated.

Water

Except following dehydration or certain abnormal physiological states, one does not ordinarily gain weight by an excessive ingestion of fluids. The normal compensatory mechanisms quickly cause excretion of the excessive amounts of fluid to restore equilibrium.

Inadequate intake of fluid however, especially if coupled with excessive loss of both water and salt (as can occur in August, September, and later in Maryland) can result in substantial weight loss. This is not however the type of weight loss which is beneficial to the player or coach and can certainly be detrimental and even dangerous to the point of death. Dehydration, that is the excessive loss of body water, can cause (in addition to weight loss) a decrease in plasma water with a decrease in blood volume followed by decreasing flow to the body tissues and therefore a decreased delivery of oxygen. In addition there is a decrease in the blood flow through the kidneys with decreased ability to excrete acids. Both of the latter cause an increase of acid accumulation within the body or the condition *acidosis*. The body temperature and heart rate rise, the output of the heart (cardiac output) falls and there is exhaustion and collapse.

In a hot and humid environment the loss of salt and water can cause heat cramps, heat exhaustion and finally if persistent and severe, heat stroke and death. The measuring of weight loss on a daily basis can be a valuable clue to the coach or trainer, especially in the early practices and games of the late summer and fall. Rapid fluctuations of more than one to two pounds are always due to changes in fluid balance. All candidates should be weighed before and after each practice session. Any boy losing more than five pounds, which amounts to approximately ten quarts of body fluid, must be carefully watched. Any individual approaching a ten pound weight loss (20 qt of fluid) must be especially watched, controlled, instructed and very severely

restricted if necessary. This is an individual bordering on the dangerous fluid losses preceding heat stroke. Free access to water or preferably dilute salt solution on the field during all practices and games must be assured, and a priming dose should be encouraged during the suiting up period. Salt tablets and salt solutions should be encouraged and provided. The other precautions of temperature, humidity and unlform previously outlined should be followed.[4]

The changes in weight due to water loss are primarily important in order to avoid dehydration, heat exhaustion and possibly heat stroke.

Fat

Here, really, is the weight controlling variable of which we are all really thinking when this subject is being considered. The previous points were made primarily to keep one reminded that putting a boy on the scale does not necessarily measure only fat tissue loss or gain but also the other variables. As mentioned previously, this fat tissue is deposited whenever caloric intake exceeds utilization. Energy is needed by the body first for what is called *basal metabolism*. These are the basic needs of life namely to maintain body temperature, to maintain the autonomic (automatic) functions of the body such as the heartbeat, respirations, gut function, etc. and then the synthetic tissue reaction such as forming proteins and the other chemical reactions of the body. One requires energy also to perform the daily activities which are not really productive work but still essential, such as feeding and clothing. The last portion of energy expenditure is that which is essential in performing one's daily work whatever it may be.

The basic metabolic functions consume about 1500 calories daily (500 while asleep and 1000 while awake) while the daily necessary activities require approximately another 500. These 2000 calories are needed to perform *non-labor activities*. *Work activities* may vary from 600 calories for a really sedentary individual to as high as 3000 calories (approximately) for a really active athlete.

The caloric value of food consumed varies with its composition. Carbohydrate develops four calories per gram as does protein whereas each gram of fat consumed produces more than twice as much—nine calories per gram. Ethanol (alcohol) delivers approximately seven calories per gram. It is extremely easy with the usual adolescent diet to exceed the 2500 calorie requirement for sedentary and even the 3500 to 4000 calories of the athlete. It only takes a few milkshakes, french fries, hamburgers, chocolate bars plus the usual feedings to accomplish this and therefore gain weight. It is obviously more difficult to lose one pound of *fat weight* which requires the utilization of 3500 calories in excess of intake. This implies that the decreased intake of calories is essential in any program of true fat tissue loss almost in spite of the exercise program involved.

Adjuncts

Diet Pills: Although these may be helpful in decreasing appetite under ordinary circumstances they are contraindicated in the actively training individual, especially during the heat acclimatization period of the fall. The secondary cardiovascular side effects and the reported deaths while taking these stimulant drugs in hot and humid weather make it essential that they not be used.

Special Foods: In spite of the obvious food fadism especially among some of our professional athletes there is, at the present time, no demonstrable, experimental proof that honey, wheat germ, rose hips, kelp, corn oil, etc. are helpful in increasing performance or stamina. I have never felt it essential however to insist that the athletes discontinue the use of these especially if the individual is convinced of their value. Conversely, coaches, trainers, and physicians should not encourage these supplements since they certainly are not helpful and perhaps place wrong emphasis on their value versus training. Some of these foods in addition, cause gastrointestinal upset and it would seem foolish to risk nausea, vomiting or indigestion prior to an athletic contest in order to gain a minimal psychologic and a nonexistent physiologic effect.

Vitamins: No vitamins have been shown helpful including injections of Vitamin B-12, high potency B vitamins, Vitamin E, etc., etc., etc. in spite of what is written in the lay press and in spite of what some trainers and even the physicians of some teams seem to encourage.

Salt: It is essential to have salt supplied in large quantities along with adequate fluid in the training and acclimatization periods. Once again this is not one of the things that can be done on the day of a game. The salt and fluid stores of the body have to be built up over the ten days to two weeks which are necessary for heat acclimatization in order to be valuable. It is not worth risking nausea and vomiting in pushing salt pills on an individual the day of the game. The athlete must be encouraged to take the salt as tablets and in liberal quantities on food during the training period. Much more essential is the provision of adequate fluid in liberal and unrestricted quantities on the field for the game, perhaps in the form of palatable salt solution but even as water.

Pre-game Meals: Depending on the state of excitement and the type of food (such as fat versus carbohydrate versus protein) it will take two to six hours or longer for the stomach to empty following

a meal. The only advantage of a liquid meal might be if it were more easily digested and tolerated, without nausea or vomiting. Regardless of the long history of traditional meals prior to a game that many teams use, physiologically nothing ingested on the morning of the game (or between halves of the football game) will have any effect on performance. A proper diet during the previous days and weeks building up glycogen stores, etc. is much more important to adequate performance on the day of the game.

Ideal Weight: The ideal weight for any individual varies depending on height, body stature and muscular development. It varies somewhat from sport to sport. Comparing a long distance runner with a football interior lineman as to adequate and ideal weight, using the same standards, would obviously be unreasonable for their muscular development is entirely different. We are considering muscle weight and not a *flabby fat boy*. There are many tables available, some of them quite elaborate including hip measurements, chest measurements, etc. but simple height and weight tables usually suffice. Most often a coach or trainer can look at one of his candidates and tell whether or not it is fat or muscle in the overweight suspect. There is a tendency among some football coaches to like *heft* in their line regardless of whether it is fat or muscle. I think however, most of the better coaches would agree that usually a 210 pound fat boy is going to be moved by a 190 pound muscular, agile individual of the same size.

As far as wrestlers and their coaches are concerned, we have another problem. They are interested primarily in what the lowest weight would be to allow the athlete to compete in the lightest category possible. This varies of course with stature but the various devices used in the past and even the present to make the "weigh in" are to be deplored. As is obvious from our previous discussion rapid weight losses are always due to water and salt loss. These deficits of dehydration cannot be repaired within the several hours prior to a match and still expect the athlete to perform well or even safely. Nor is it reasonable to keep a boy on a semi-starvation or dehydrating diet to help him stay within a given weight class and expect him to perform safely.

Can anything be done to avoid the weigh-in problems especially of a sport such as wrestling? Should weighing in before matches be completely abolished? A recommendation has been made that all boys out for wrestling be weighed on a surprise weigh-in twice a year, placed in a weight category and left there for the rest of the year regardless of change. Another plan would weigh the wrestler after four to six weeks of training and make that his minimum effective weight.[5] Some change may be due!

Summary

Obesity is undesirable in any athlete for it impairs his ability to perform to the maximum of his own personal, ultimate capabilities.

True (fat) weight loss can only be attained by hard physical work and decreased food intake, especially of the high caloric foods, so that the energy expended is in excess of the calories ingested at the rate of 3500 calories per pound of fat.

Special foods, such as honey, wheat germ, etc. are of no help and should not be encouraged. For an individual who is already convinced of their efficacy and using them, controversy can be avoided unless they are shown to cause him gastrointestinal upset or other detriment.

No diet pills, Vitamin B-12, anabolic steroids, etc. are necessary or desirable. Certain of these can cause toxicity and be detrimental.

No rubber suits should be encouraged or tolerated for they do not cause true fat weight loss but only fluid loss and have been implicated in precipitating heat stroke.

Rapid weight fluctuations of any magnitude are due to fluid shifts and do not represent *fat* weight loss or gain and therefore are not of themselves desirable. Chronic or acute dehydration can be extremely dangerous to the athlete, especially so in hot, humid weather.

I hope that all of the coaches, trainers, physicians and educators present will give serious consideration to the problems of weight in our athletes. Although obesity is undesirable, the opposite viz. artificially induced and excessive weight loss by dehydration and semistarvation is to be condemned. We must all be alert to safeguarding the individual above all, even to the detriment of the team if necessary. Standards must be reviewed, modified or discarded if unsuitable. These standards must be so arranged that all teams can compete without unfair advantage, and without compromising the safety of the individual athlete.

REFERENCES

1. Dempsey, J. A., Reddan, W., Balke, B. and Rankin, J.: Work Capacity Determinants and Physiologic Cost of Weight-Supported Work in Obesity." *J of Appl Physiol* **21**:1815-20, November 1966.
2. Murphy, R. J. and Asle, W. F.: "Prevention of Heat Illness in Football Players." *JAMA* **194**:650-654, 8 Nov 1965.
3. Best, C. H. and Taylor, N. B.: *The Physiologic Basis of Medical Practice*. Eighth Edition. Baltimore: Williams and Wilkins Co., 1966.
4. Maganzini, H. C.: "Heat Adaptation and Injury in Football Players." *Md Med J* **16**:45-49, October 1967.
5. "Wrestling and Weight Control." AMA Committee on Medical Aspects of Sports. *JAMA* **201**:541-543, 14 August 1967.

It is interesting to note that the pamphlet published by the American Medical Association entitled, "Medical Evaluation of Candidates for School Sports" makes no mention of the cutaneous lesions that should disqualify a candidate for participation in athletic activities. It should be obvious that conditions such as, acne congoblata, furunculosis, impetigo contagiosa, monilial infections, plantar warts, swimming pool granulomas, mycotic infections, and contact dermatitis would disqualify a candidate for participation until the condition shows a satisfactory response to treatment. More adequate instruction should be given about the necessity for, and methods of, complete examination of the skin.

Skin Problems in Athletics

HARRY M. ROBINSON, JR., MD
Professor of Dermatology
University of Maryland School of Medicine

Many hazards face the person engaged in sports. The skin is readily subject to injury. Participants may develop eruptions or aggravate previously existing skin lesions.

Fungus Infections

The term "Athlete's Foot" has been applied to a variety of lesions that affect the feet. It has been assumed that these foot lesions are due to fungi, therefore various popular remedies are used in treatment by physicians and athletic instructors as well. Unfortunately, in the vast majority of instances, attempts are not made to establish the diagnosis by proper laboratory methods.

Only a very small percentage of patients with so-called Athlete's Foot, actually have fungus infections, but because of the ill-advised use of many different medications, a large number develop eczematous eruptions. Lesions commonly mistaken for fungus infections may be dyshidrosis, shoe dermatitis, psoriasis, or bacterial infections. Specific medications should never be used until the diagnosis is established. Self-medication must be discouraged.

Fungus infections of various types are common occurrences, but the degree of contagion is not quite as great as popular opinion would have us believe. They do not constitute a major problem among athletes. The person who has the fungus infection is uncomfortable and needs competent diagnostic and therapeutic care. Fortunately, specific drugs are available for the treatment of most fungus infections, but must be prescribed by a physician. (Most of the patent medicines are worthless.)

Bacterial Infections

Bacterial infections are troublesome because they are readily communicable. Pyogenic infections are relatively easy to control by antibiotic therapy, but until the lesions have completely healed, the patient should be restricted from physical contact with other persons.

The swimming pool granuloma is a chronic infection caused by an atypical acid fast bacteria. These lesions, which appear as warty growths, are most commonly found on the elbows and knees. They should be removed surgically by wide excision in order to prevent recurrence. A culture should be made from the cut surface of the excised material to rule out the possibility of tuberculous infection.

Viral Infections

The sports world should be grateful to Dr. Lester Dyke, Head of the Student Health Department of the University of Maryland at College Park. Dr. Dyke recognized the communicability of herpes simplex among wrestlers. This is a common troublesome condition for which there is no specific treatment.

Molluscum contagiosum is another relatively common virus infection of the skin, but is not readily transmissible.

Allergic contact dermatitis may develop from exposure to grass, rosin, soap, perfume, body lotions, liniments, etc Practically all substances have some sensitizing potential.

Plantar corns and warts are painful lesions for which there is no specific treatment. Surgical procedures are to be avoided. The plantar wart is caused by a virus, whereas, the corn is due to local irritation. Only an experienced physician can differentiate between the two. Although warts are thought to be non-contagious, they are infectious and there is little doubt that they occur most frequently in dormitories where community baths are used. These plantar lesions should never be treated by an untrained layman, and further local irritation with patent medicines must be avoided. Irritation and extension of the lesion may be caused by prolonged use of rubber shoes. Although radiation therapy has been advocated, it is only successful in a small number of patients and, unless given by an expert, may produce great damage.

Bacterial infections may complicate traumatic blisters contact dematitis, eczema, fungus infections, and dyshidrosis. If not treated promptly and properly, severe damage may ensue. Fortunately, specific antibiotic therapy is almost invariably successful in eradicating such infections.

Allergic contact dematitis may develop from the materials used in shoe manufacture.

The use of foot baths in shower stalls is to be condemned because these troughs are a haven for bacteria, fungi, and filth. These baths are ineffective. It makes little sense to have 40 or 50 people walk through the same trough going to and from the shower. A much safer and more effective method of prophylaxis is the use of alcohol on the feet and between the toes immediately following the bath.

As a general rule, acne vulgaris should not be a limiting factor in sports participation. In some patients, the large cystic lesions and draining sinuses are a contraindication to participation in contact sports.

Exposure to sunlight may cause an eruption or may aggravate an existing lesion. We have come to recognize photosensitivity eruptions following drug administrations, or the topical application of remedies. Some soaps will sensitize the skin action to sunlight.

Summary

The physical examination performed on sports participants should include a careful examination of the integument. A careful record should be made of all cutaneous abnormalities, regardless of how small or insignificant. Whenever possible, corrective measures should be taken or specific therapy administered. If the lesion is such that it will be aggravated by trauma or exposure, it should be corrected or the patient should be restricted. If infections develop during the course of athletic activities, they should be corrected immediately by a competent physician. Amateur therapy is not to be condoned.

Medical Aspects of the Obese Child in Athletics

MILTON S. GROSSMAN, MD
Associate Professor of Pediatrics
University of Maryland School of Medicine

Obesity can be determined in an individual by comparing weight to height. One of the most satisfactory charts for this purpose is the one based on Stuart's data. Stuart and his group in Boston were interested in anthropometry, the classification by body type—ectomorph, mesomorph, and endomorph—according to body habitus. This is an important concept to consider. There are numerous muscles in the body and mere weight does not reflect body mass, or the proportion of body mass that is fat.

You cannot use a weight chart alone. For example, a professional football player, weighed when naked and dry, will be immensely obese according to standard health charts. But, place him in an immersion tank and then weigh him and he fits the chart. The reason for this is that fat rises and the more fat you possess the lighter you are in water. By this method, ie, weighing and individual wet vs dry, one can demonstrate how an athletic program —physical fitness—actually changes the proportion of fat to muscle which is a constructive way of evaluating obesity, and the effect of an integrated athletic program.

Measures for Obesity

The mesomorph is the muscular, powerful fellow. The endomorph is the fat, sloppy, overweight individual, and the ectomorph is the exquisitely thin-structured person.

In dealing with children and adolescents, a very much simpler method of evaluation is utilization of the chart adapted from the Stuart data. A study of healthy American children—by the thousands—would reveal that 94% of them fall within what is considered the "ideal" on the chart. Of the remaining 6%, 3% would be below the line on chart, but would still be considered normal, and 3% would be one extreme or the other—either very thin or very fat. For example, at age 12, 50% of female children studied would be taller than 58 inches, and 50% would be shorter than 58 inches. The person who falls within the 97th percentile in weight should fall within 97th percentile for height in order to be ideal. Twenty-five percent fluctuation is allowed, however.

Obesity is said to be a greater than 50% increase of weight for height. Malignant obesity—the extreme —is greater than 100% weight for height. For example, if a person should weigh 50 lb at a given age, obesity would mean that he would weigh 75 lb, and malignant obesity would have him at 100 lb.

Of course, the ratio of weight to height depends upon body habitus, body size, and hereditary aspects.

Karen Whitehouse, in 1962, studied 25,000 children of various ages in London. She used a simple technique to define obesity in this group skin caliper measurements, from the triceps region of the muscle at the inferior level of the scapula, were taken. This is the best place to measure skin folds and fat. Her studies indicated that there were striking differences in the children and body habitus, and from this data, Whitehouse's group constructed a chart that is very similar to the Stuart data chart. Boys and girls grow at a fixed rate; they accumulate fat at a fixed rate from birth through adolescence. A 12-year-old boy, for example, with a skin tricep fold of 4.5mm would be in a third percentile of the group. With a skin tricep

fold of 22mm he would be in the 97th percentile. The statistical range would be from 4.5 to 22 with a mean of 9mm for boys. Girls, on the other hand, would have a range that starts at a 4.5mm in the third percentile, but would go up to 25mm at the 97th percentile. The mean for girls would obviously be higher.

After age eight, girls accumulate fat more rapidly than boys, but from age two on boys and girls accumulate fat at the same rate.

Why is it Important to Approach the Obese Child?

If a child finishes his adolescent growth spread in an overweight condition, his chances of being slender as an adult are markedly diminished. Therefore, it behooves the physician to concentrate on weight control before the completion of growth.

Dr. Mayer, a nutritionist in Boston, and well-known lecturer on obesity, has given us a lot of statistics on obesity. In a given population of 15 year olds with one obese parent for each child, 20% of the adolescents will be obese; if both parents are obese in this population, 80% of the adolescents will be obese. We must, therefore, consider that heredity plays a definite role, and further, it is difficult to differentiate between heredity and environment. Obviously, if both parents of a child are obese, they may have acquired obesity as adults and this may reflect emotional maladjustment and many other things. Nevertheless, it is important to recognize that the body habitus of the parents bears a very strong relationship to how the child will grow.

The Defect of Obesity

Inactivity is the primary defect of obesity. The one fact that permeates this entire population is that the more obese an individual is, the more inactive he is; and the less active he is, the more obese he becomes. It is a very difficult and frustrating cycle for the physician.

An individual who is obese as an adolescent is rejected by his peer group. He is not accepted in sports, either in or out of school. This is all very distressing to the adolescent and he goes home and sits and watches television, and snacks. Most studies of obese adolescents have revealed that they eat a very poor breakfast, a very slight lunch, and then indulge in "wall-to-wall" eating from the time they come home from school until they go to bed. Most adolescents are night time eaters. It is the wall-to-wall pattern we have to break.

Obesity in the growing child is the accumulation of more fat cells, just like increasing muscle mass is the increase in protein and cell number. Obesity in the adult is the increased fat content of cells that are already present. If a person is to grow significantly, he must increase the number of cells he has, but if he does this by increasing his fat cells, the process is irreversible after growth has ceased in the rest of the body. One can go on all sorts of diets and decrease the volume of the cells—the cell size—so that he looks more compact, but the slightest slip from whatever weight control group he is involved in and he blows up again. Therefore, to protect the adolescent from a weight problem as an adult, one must prevent an excess growth of fat cells during these important years.

An adult athlete accumulates fat at an extraordinarily rapid rate once he becomes inactive, but on the other hand, it doesn't take much physical activity, although it has to be continuous, to get him back into shape, because the number of fat cells in his body are relatively few in comparison to the chronically obese non-athlete whose obesity dates back to adolescence.

The public is well aware of the health aspects of excess weight, such as, diabetes, cardiovascular disease—it should be the physician and athletic director's goal to help prevent these costly complications of modern life.

An Obese Child in Athletics

Physicians are called upon to screen children for athletic programs. Somehow the physician is supposed to tell athletic directors whether or not a child is healthy; he is supposed to separate an obese child from ideal children and recommend that he not participate in sports, even if his obesity is not clinically significant, for fear that if he were to participate, he might do harm to himself. Unfortunately, our physician group, with few exceptions, has not been adequately interested in this particular aspect of medicine. One cause of this inertia may be that we have physicians who are responsible for athletes and athletic teams who have never been athletes themselves. Consequently, they do not understand the dynamics of what athletic directors are trying to do anymore than athletic directors understand what the physicians are trying to do. There is a definite lack of communication—the goals are different. It should be the objective of both the athletic director and physician to involve the obese child in athletic activities as much as possible.

In my own practice, child after child comes to my office for obesity and weight control with a slip from his physician to the physical education teacher stating that the child should not participate. This, without a doubt, is the worst thing in the world that could happen to a child in the majority of cases. It needs to be pointed out that it is vitally important for the physician to distinguish between the child with endocrine obesity, ie, some glandular disturbance which is exceedingly rare, and the child with exogenous obesity—he just eats too much. The distinction is really very simple. A child who is growing well is a child who is tall, and fat, normal children are taller than their peer group. All medical causes of obesity cause growth to fail.

On the other hand, a normal, fat child may have high blood pressure and if this is the case, it could be risky if he were to participate in vigorous sports. Most high blood pressure, however, is just an artefact of inadequate equipment and improper observation.

One of my former colleagues, Warren R. Guild, MD, of Boston, has written a delightful book entitled "How to Stay Fit and Enjoy it." It was published by Harper & Row in 1962. The book covers the dynamics of physical fitness, obesity, nutrition, and a variety of other subjects.

What we know about the medical aspects of obesity in athletics came from the so-called Pheidippidian physiology. Pheidippides was a great Greek runner who set the pace for all subsequent marathons. (He was not, however, the courier who ran from the Battle of Marathon to Athens and whose first words on arriving were, "Rejoice, we have won!" and then he dropped dead.) Pheidippides enjoyed running and knew how to conserve his strength. He introduced the concept of the correlation between nutrition, training, stamina, and physical development. There is an excellent article in the *New England Journal of Medicine*, December 12, 1967, entitled "Echoes of Marathon" which I urge you to read. It is from a symposium of marathon people and physicians and is one of the best articles ever to come out on the medical aspects of sports.

One of the most important roles of an athletic director is to prevent inactivity and encourage massive activity. There is no question that the obese individual can, with training, withstand the same rigors of sports as any other individual. In discussing the problem with some coaches in Boston, the conclusions we came to included the necessity of having a good physician to screen the adolescents. This has to be a physician who is interested in, and who understands athletics, and is willing to work with overweight adolescents. The coaches said they have been amazed that even in basketball the overweight child, who really is motivated, in an integrated program can develop fantastic speed. Four things that are important include motivation, integration, skill—in the sense that they should have some coordination—and a consistent well-integrated, well-constructed training program.

From a Medical Point of View

The obese individual has a very high level of fatty acids in the blood. This is how we can medically tell the obese individual without even looking at him. Other clinical situations in which fatty acids are elevated in the blood include pregnancy, starvation, menstruation, and acromegaly—the excess of a growth hormone.

We know that the level of fatty acids in the blood is a balance between the effect of growth hormone and insulin. We know that if the fatty acids are elevated, a child can have a diabetic-type glucose tolerance curve. The higher the fatty acids are elevated, the insulin sensitivity, that is the ability of tissues to respond to insulin, decreases. In other words, the longer one preserves fat, the less sensitive the cells are to the immobilization effects of insulin.

Both starvation and obesity result in a high level of fatty acids. In a sense, another way of describing this is that such evidence suggests that both of the conditions are profound metabolic derangements. In summarizing all of our research on this, we have found that, with physical fitness programs, we can lower fatty acids very strikingly. We have also found that if we take fatty acid levels on a healthy adolescent population at the beginning of a season, and then take them after they are "physically fit" they will have been lowered.

Summary

We now have been able to show, after much research and work, that there are medical correlations with metabolism of food stuffs and the excess accumulation of fat. With diet plus exercise, with this creation of activity, one can change the metabolism. The diet most successful in creating this change is a very high protein diet. The high protein diet we use is 30% protein in contrast to the normal American diet of 15% protein, 25% carbohydrates, and the rest comprised of unsaturated fatty acid.

My own studies suggest that within the next 10 to 15 years, the American diet will be very high in protein. The high protein diet has many advantages —it is filling; so that one can eat a lot less, and, therefore, consume fewer calories per unit. An obese child is fed five or six times a day. This is how children normally eat. Coupled with exercise the child enjoys, and this is the key to physical fitness, the child will willingly participate and the rest will really be on his own doing.

A high protein diet seems to produce (we aren't positive yet) better physically fit individuals. However, four hours before this individual is to participate in a strenuous athletic event, he should be given a high carbohydrate meal. The reason is that protein has to be burned as a metabolic acid and has to be excreted through the kidneys, and the kidneys work very poorly during vigorous athletic sports. One needs instead, a high carbohydrate feed prior to, and subsequent with, the rigorous activity.

In essence, what I have said is that an obese child needs to be encouraged to participate in athletic activities, and needs to be observed by a physician who is willing to supervise the child's diet and exercise. In effect, the child needs to be told that there is no physical disability connected with his obesity and that, with a little bit of participation on his side, he need not be obese.

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on Thursday, June 5, 1969, and took the following action:

1. Authorized expenditure up to $350 for co-sponsorship with the Communicable Disease Center, USPHS, of a symposium on Viral Diseases in November 1969.
2. Agreed to present AMAERF checks at the Presidential dinner rather than at House of Delegates sessions at future annual meetings. This is being done at the request of the Woman's Auxiliary which is instrumental in raising funds for the presentation of these checks.
3. Authorized the Program and Arrangements Committee to make suitable arrangements for a tour of the Orient in May 1970.
4. Heard that the President, President-elect, Council Chairman and Executive Secretary attended a conference sponsored by the Governor on Wednesday, June 11, including dinner at the Governor's mansion and an all-day session on Thursday aboard the Governor's yacht.
5. Heard the results of a meeting with the Governor and Secretary of Health on May 27, when the President, President-elect, Council Chairman, and Executive Secretary discussed mutual problems in the health fields.
6. Heard that John C. Krantz will act as the Faculty representative at the 1970 U.S. Pharmacopeial Convention in Washington, D.C.
7. Approved proposed new laboratory licensure regulations with amendments, as suggested by the Maryland Society of Pathologists.
8. Heard and adopted a report of the Ad Hoc Committee on Consent Forms and agreed to notify chiefs of staff of all hospitals that copies of the suggested forms are available on request.
9. Agreed to continue financial support to a member's wife and family while he is hospitalized, with the understanding that the case will be reviewed again in six months time.
10. Agreed to consult with the Secretary of Health in connection with a proposal that the Commission on Medical Discipline law be changed so that the Faculty would submit the names of 24 individuals from which appointments to this Commission would be made.
11. Agreed to invite Ray Holden, MD, Washington, D.C., a member of AMA Board of Trustees, to a future Council meeting to discuss AMA policies.
12. Heard that William J. McClafferty, MD, Baltimore, has been named by the Workmen's Compensation Commission Chairman to serve on the Continuing Committee to Study the Workmen's Compensation Medical and Surgical Fees.
13. Authorized advising the State Health Commissioner that the Faculty is willing and anxious to assist in discussing Rx practices of physicians, but needs adequate information with names and data before it can pursue such investigations.
14. Agreed to look into the question that has been raised that Blue Shield is interfering in connection with patient charges when a physician is not a participating physician with Blue Shield.
15. Met with a counterpart group from the Maryland State Dental Association to discuss mutual problems.

The Executive Committee met on Thursday, June 19, 1969, and took the following action:

1. Reaffirmed the position that the brochure published by the Faculty dealing with the Commission on Medical Discipline was directed to physicians and to members only. No attempt is being made to regulate lay laboratories or to determine what is ethical or unethical for such groups.
2. Authorized legal counsel to direct a letter to attorneys who query Faculty action in this regard.
3. Established a date of July 24, 1969, for the next meeting of the Executive Committee to handle any business that has accumulated by that date.

The Council met on Thursday, June 19, 1969, and took the following action:

1. Adopted minutes of previous meetings of the Council and Executive Committee.
2. Declined to provide "expert witnesses" to the U.S. Department of Justice, Bureau of Narcotics and Dangerous Drugs, to assist the government in prosecution of criminal cases involving persons in the medical profession on the grounds that no provision is contained in the Faculty Bylaws for such action, and on the advice of legal counsel.
3. Adopted a policy statement on Sex Education and Family Life Planning which reads as follows:

   The Medical and Chirurgical Faculty of the State of Maryland recognizes that the primary responsibility for sex education will always remain within the home, but the school, church, and some other community agencies have a supplementary role in reinforcing and supporting the efforts of the home.

   The Faculty supports the inauguration and implementation within the school system of a family life and sex education program which will fill the following criteria:

   1. That it be part of an over-all health education and biology program;
   2. That it be presented in a manner commensurate with the maturity and emotional level of the students;
   3. That the sex education course follow a professionally developed and regulated curriculum;
   4. That the sex education program attempt the medical societies (both state and city) be community in the classroom teaching situation;
   5. That the sex education program utilize classroom teachers and other professionals and sub-professionals who have shown an aptitude for working with young people and who have received special training;
   6. That the sex education program have as consultants, advisors and resource persons: physicians, nurses and public health personnel to be responsible for the *development* and guidance of such a curriculum, and that the medical oscieties (both state and city) be encouraged to take an active part.

4. Agreed to publicize the above statement through "all Communications Media."
5. Endorsed, in principle, a proposal for a pre-school hearing and vision screening survey program, and authorized the Treasurer and Executive Committee to approve expenditure of the necessary funds to implement this.
6. Authorized employment of a press consultant for the 1969 Semiannual meeting; and for inclusion of funds for such employment for the 1970 Annual and Semiannual sessions in the 1970 budget and thereafter.
7. Accepted with regret the resignation of Louis A. M. Krause, MD, from the Library and History Committee; and named Paul F. Guerin, MD, to serve in his place until the 1970 Annual Meeting.
8. Adopted an expression of appreciation to Vernon H. Norwood, MD, for his many years of service on the Board of Medical Examiners.
9. Approved recommending to the House of Delegates Emeritus membership for various members, on the recommendation of the Baltimore City Medical Society.
10. Agreed to recommend a standing rule to the House of Delegates dealing with reports by other than Committee Chairman, Officers, etc., which would limit such verbal reports to five minutes with the understanding that the full report could be printed in the transactions of such sessions.
11. Declined to approve a proposed Glaucoma Screening Project in the form presented, and because support of the organization involved in providing the screening population had not been obtained.
12. Accepted a report from the Ad Hoc Committee on Tuberculosis and discharged it with thanks.
13. Received financial operating and dedicated fund statements through March 31, 1969.
14. Heard of receipt of an additional sum of money to be added to the Laughlin Award Fund, which now totals $2,906.83.
15. Asked for suggestions for consideration by the AMA Board of Trustees for possible appointment to various AMA Councils and Committees.

16. Adopted the following policy statement in connection with Drug Abuse Treatment Centers:

That the Medical and Chirurgical Faculty of Maryland endorses the concept that selected hospitals be encouraged to establish drug abuse treatment centers under their auspices, either as part of, or at some reasonable proximity to, its hospital facilities, under strict professional and administrative controls, and using accepted methods of treatment and ancillary personnel, such as medical social workers, psychologists, nutritionists, etc., as well as psychiatrists, internists, pediatricians, etc.

It is understood that such selected hospitals must have adequate staffing, resources, financing, space and other facilities, and that they would conform with the Ethical Guidelines for the Treatment of Narcotic Addicts, as adopted by the Medical and Chirurgical Faculty.

17. Adopted the folowing statement in connection with Multiphasic Screening Programs:

The Ad Hoc Committee to Discuss Multiphasic Screening Programs concurs with the feasibility report submitted by the Bendix Corporation and recommends its acceptance. It further believes that this concept is worthwhile, even though still in its infant stage, and that lines of communication should be kept open with the Bendix Corporation or other groups so that implementation could take place in the event changes occur in our social and environmental setting.

The Committee also recommends that the Faculty go on record as being interested in instituting such a program under Faculty sponsorship, in the event it does become feasible. The Committee recommends that this subject should be reconsidered at regular 6 month periods.

18. Authorized the Bylaws Committee to study the question of dentists serving on various Faculty committees.





DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Rehabilitation of Patients Suffering from Fracture of the Hip*

Part II: Treatment by Hip Pinning

JOHN D. HSU, MD
Division Orthopaedic Surgery
Department of Surgery
Baltimore City Hospitals
Johns Hopkins Medical Institutions

Rehabilitation of patients following the operative treatment of fracture of the hip by hip pinning is an essential part of the over-all management.

In the specific orthopaedic treatment of fracture of the hip, the introduction of open reduction and internal fixation by Smith-Petersen,[1] together with the development of suitable metals for internal implantation [2] has revolutionized the treatment. The unfortunate past experiences and poor prognoses described in earlier textbooks in the treatment of such fractures,[3, 4] and the descriptions of the tremendous discomfort and agony suffered by such patients are rarely seen now.[5] Smith-Petersen's idea was developed mainly for intracapsular fractures. His method was open reduction of the fracture, followed by introduction of the nail for fixation. Today, the preferred method of surgical management is extra-articular hip nailing, after closed reduction of the fracture under radiographic control. This method can be used for many types of hip fractures.

The patients under consideration suffered acute hip fractures and recovered without major complications. Such cases comprise the majority of instances for which hip nailings are done. The study does not include patients who were unable to walk prior to the operative procedure or patients with metastatic or other terminal illnesses.

* *Supported in part by an American Geriatrics Society Award and USPHS Grant No 5T1 GM00624-08.*

Evaluation and Postoperative Regimen

Since every patient with fracture of the hip is a potential operative candidate, initial assessment should include the procurement of information helpful for postoperative planning. Rehabilitation should be considered as early as possible so that planning can be done at the earliest moment.

The physical evaluation of the patient and the administration of the MSCL and ADL tests are usually made at a time when the patient's condition has stabilized and improved to an extent where sufficient information can be obtained for planning.[6, 7] Physiologically, the earliest time possible during the convalescent period that the patient can give a meaningful answer is when tissue catabolism has stopped and recovery has started. This has been called the "Turning Point Phase."[8] At this time, the patient has started to show an interest in other people and his surroundings. He can concentrate and become cooperative with the tester. It often takes three or four days to a week before the patient becomes completely interested and is capable of performing a "test" to determine his mental status and physical ability. In older patients, more time for recovery should be allowed.[9]

As the delay for this optimum period is usually not great, and it does not interfere with the treatment and prolongation of hospitalization, the treating physician has a chance to assess the problem at hand, together with others that may become manifest during the postoperative period.

In consideration of rehabilitation, patients with fracture of the hip treated by hip pinning should be divided into three age groups in relation to the special problems encountered. Such a classification is also of value for making a prognostic prediction, but individual considerations are important.

I The young age group (up to age 54)

II The intermediate age group (55-64 years)

III The older patient (over age 65)

Results

Studies were made at the Baltimore City Hospitals, between 1963-1968, of patients suffering from fracture of the hip. In cases that met our previously stated criteria, the MSCL, ADL tests were administered, in addition to a general clinical evaluation in the Department of Physical Therapy and Rehabilitation, prior to the institution of a rehabilitation program for each individual patient. It was found that patients in Group I and Group II, treated by hip pinning, showed a distribution of MSCL scores on initial testing to be higher than 36 (out of a maximum score of 50) with a mean at about 40. The mean ADL score was approximately 50 out of a maximum of 100. This score was reasonable because the patients were unable to perform the walking activities in the early postoperative period. In Group III, the older patient, the mean ADL score was about 35 and the mean MSCL score between 25 to 30; both figures are appreciably lower than in the younger age groups.

At the time of conclusion of the active rehabilitation program and discharge from the Physical Therapy Department, 88% of Group I patients showed an ADL score of between 80 to 100, and 97% of the patients were independent on crutches. Active rehabilitation measures were discontinued as these patients gained the maximum benefit and progressed well independently. This improvement was seen in a period of less than one month. Of 77% Group II patients, on final testing scored between 80 to 100 on the ADL test, with much improvement also seen in less than one month; 70% were ambulating on crutches; 25% needed the assistance of a walker. Most patients continued some form of contact with the Physical Therapy Department from receiving simple guidance and reassurance to transfer and gait training activities, after one month time had elapsed from the time of the initial test, in addition to their scheduled regular orthopaedic clinic visits.

Group III patients showed improvement over a much longer span of time. At the time of discharge from hospital, over 40% remained dependent on a walker, while the more elderly were dependent on a wheelchair or bed and needed continued active care and rehabilitation.

Thus, the age difference is most important in discharge planning, as well as in selecting the aids necessary for maximal benefit. The initial postoperative examination, and evaluation with the MSCL and ADL are also helpful. A regimen planned with the help of these measurements is useful in the rehabilitation of patients with fracture of the hip, treated by hip pinning.

REFERENCES

1. Smith-Petersen, et al: Intracapsular Fractures of the Neck of the Femur: Treatment by Internal Fixation, *Arch Surg* **23:** 715, 1931.
2. Watson-Jones, R.: *Fractures and Joint Injuries,* ed 4, London: E. & S. Livingstone Ltd., 1962, vol 1.
3. Bigelow, H. J.: *Dislocations and Fractures of the Hip,* Boston: Little, Brown & Co., 1900.
4. Stimson, L. A.: *Treatise of Fractures,* Philadelphia: Henry C. Lea's Son & Co., 1883.
5. Hudack, S. S., and Cooke, R. F.: Restitutive Surgerv of the Hip Joint: Its Evaluation to the Present, *J Amer Ger Soc* **2:**56, 1954.
6. Carroll, D. G.: Measurement of Performance in Rehabilitation: Activities of Daily Living (ADL), *Md State Med J* **17:**113, 1968.
7. Carroll, D. G.: Measurement of Performance in Rehabilitation. Orientation, *Md State Med J* **17:**127, 1968.
8. Committee on Pre- and Postoperative Care. American College of Surgeons, *Manual of Preoperative and Postoperative Care,* Philadelphia: W. B. Saunders Co., 1967.
9. Hsu, J. D.: Rehabilitation of Patients suffering from Fracture of the Hip, *Md State Med J* **18:** (Part I) 111-112, 1969.

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Highlights

The Board of Health and Mental Hygiene, which held its last meeting on Friday, June 13, traces its origin to nearly a century ago, when the first Board of Health was appointed in 1874 by Governor Groome. A joint Board, under its present title, was established in 1961 to fulfill the combined responsibilities of the Board of Health, the Mental Hygiene Advisory Board, and the Mental Hygiene Board of Review to act as the policy-making agency for the Departments of Health and Mental Hygiene.

In the years following, a succession of dedicated men and women have served on the Board and have given generously of their time and professional talents on behalf of public health in Maryland. The Health Department is grateful to the eleven members serving on the Board who have carried on the distinguished tradition of their predecessors, and we hope that Maryland will continue to benefit from their expertise in some phase of public health.

I wish to express my personal appreciation to all of those who have served on the Board during my tenure.

I look forward with great expectation to the accomplishments in the health field which can occur under the new organizational structure of the executive branch of government in Maryland. As of July 1, the Departments of Health and Mental Hygiene are combined with other health-related agencies and boards in a single department under the direction of Neil Solomon, MD, PhD, Secretary of the Department of Health and Mental Hygiene.

William J. Peeples

IN THE BUILDING AND TRADITION OF THE BALTIMORE EYE EAR AND THROAT HOSPITAL



AT THE FRANCIS SCOTT KEY MONUMENT
Near Jones Falls Expressway and State Office Building

Key Circle Hospice

NURSING HOME & EXTENDED CARE FACILITY

R. W. Hansen, *Administrator*

1213 EUTAW PLACE BALTIMORE, MARYLAND 21217

523-7800

THE BEST CARE AVAILABLE
UNDER CONSTANT MEDICAL SUPERVISION
MODERATE RATES



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of th weight-control program *you* recommend. reduces the appetite. Doesn't kill it. Weig loss is significant—gradual—yet there is relatively low incidence of CNS stimul tion. Because TEPANIL works on th appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in patie hypersensitive to this drug; in emotionally unstable patie susceptible to drug abuse.

Warning: Although generally safer than the amphetamin use with great caution in patients with severe hypertension severe cardiovascular disease. Do not use during first trimester pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of th apy, unpleasant symptoms with diethylpropion hydrochloride have been report to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasionally cause CNS effects such insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has be reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic *cardiovascular effects* reparted include ones such as tachycardia, precord pain, arrhythmia, palpitation, and increased blood pressure. One published report describ T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hyd chloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymasis, and erythem *Gastrointestinal effects* such as diarrhea, constipatian, nausea, vamiting, and abdominal disco fort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depressio agranulocytosis, and leukopenia.

A variety af miscellaneous adverse reactions have been reported by physicians. These inclu complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pa decreased libido, dysuria, and polyuria.

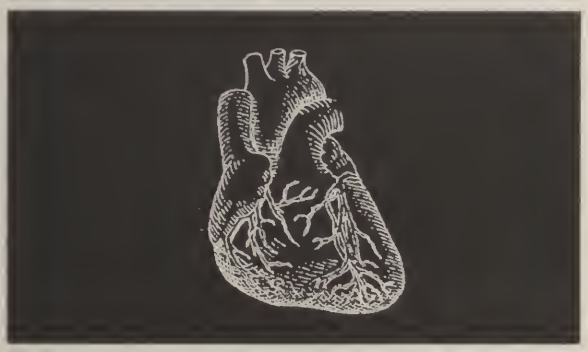
Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallow whole, In midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, ane hour befo meals. If desired, an additional tablet may be given in midevening to overcome night hung Use in children under 12 years of age is not recommended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/69



JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Arrhythmias in Myocardial Infarction

Arrhythmias associated with myocardial infarction in man have been reported in the literature for more than 40 years. These reports were based on information supplied by occasional electrocardiograms. With the advent of coronary care units in 1962, and the continuous electrocardiographic monitoring of patients with acute myocardial infarction, a new era began. More has been learned about myocardial infarction and its attendant arrhythmias in the last few years than in the more than 50 years since James Herrick published his classical account of the "Clinical Features of Sudden Obstruction of the Coronary Arteries."[1] Masters et al,[2] in 1937, reported an average incidence of arrhythmias of 17%. Today, however, a much higher incidence of arrhythmias in myocardial infarction is recognized. Some have estimated that approximately 50% of patients with acute myocardial infarction die before reaching the hospital. Therefore, data obtained from patients reaching the hospital are still highly selective with statistical bias, introduced by the elimination of deaths occurring prior to hospitalization.

The recent introduction of the mobile coronary care unit by Pantridge in Belfast, Ireland, and its use now in some areas in the United States, is expected to add even more information regarding both the incidence and type of arrhythmias encountered after acute myocardial infarction. Pantridge and Geddes [3] have estimated that ventricular fibrillation is 15 times more likely to occur during the first four hours after a heart attack than in the following eight hours.

CHRIS PAPADOPOULOS, MD
Chief of Cardiology and
Director, Coronary Care Unit
South Baltimore General Hospital

Almost any arrhythmia may occur in myocardial infarction. The early recognition and prompt treatment of these arrhythmias is extremely important since they are responsible for more fatalities in myocardial infarction than any other complication. Disturbances of conduction and failure of impulse transmission may occur within the sinus node, atria, AV junctional region, bundle of His, or Purkinje system. This may be due to exit block at the site of impulse formation or due to a retrograde or competing impulse interfering with normal impulse transmission. Disturbances of normal impulse formation may result in take over by other pacemakers within the AV node, bundle of His, or bundle branches.

Some form of arrhythmia occurs in approximately 80% of all patients suffering from acute myocardial infarction. There are some differences in the total and individual incidence of arrhythmias reported from various coronary care units, but this may be due to the method of monitoring, the length of observation, and the criteria for diagnosis of myocardial infarction. Other factors modifying arrhythmia frequency are the presence of cardiogenic shock, the site of infarction, the use of digitalis, antiarrhythmic drugs, and vasopressor agents. If one averages the incidence of the various arrhythmias reported in the series of Meltzer and Kitchell,[4] of Day,[5] and Lown and his associates [6] (totaling 714 patients), the following results are obtained:

Premature Ventricular Beats—70%
Premature Atrial Beats—40%
Atrial or Nodal Tachycardia—9%
Atrial Flutter—3%
Atrial Fibrillation—9%
First Degree Heart Block—8%
Second Degree Heart Block—5%
Third Degree Heart Block—6%
Ventricular Tachycardia—21%
Ventricular Fibrillation—6%
Ventricular Asystole—5%

Understanding the pathogenesis of these arrhythmias is very important. James [7, 8] has meticulously studied the coronary arteries and has correlated the arrhythmias associated with coronary atherosclerosis with the location of the occlusive process. The sinus node is supplied by an artery originating from the proximal few centimeters of the right coronary artery in 55% of the cases studied, and from the proximal few millimeters of the left circumflex artery in 45% of the cases. The sinus node artery is usually the largest artery supplying much of both atrial walls, as well as the node.

The depressed or disorganized function of the sinus node is usually the major contributing factor to arrhythmias during acute myocardial infarction. In coronary occlusion, the sinus node will suffer from (a) hypoxia, (b) local tissue acidosis, and (c) the liberation of certain normal intracellular constituents eg, adenosine and potassium. Acidosis (resulting from hypoxemia) has two effects: It depresses the rate of sinus impulse formation, and it stimulates local ganglia to repetitive firing and certain neuroflexes. Adenosine has been found to have a profound negative chronotropic action. Occlusion proximal to the origin of the sinus node artery has the additional effect of interrupting the blood supply to many parts of both atria. This has two particular effects relative to the onset of atrial arrhythmias: The normal course of atrial impulse propagation becomes disorganized, leaving areas of focal ischemia. Some of these foci may assume automaticity and pacemaking, especially if the sinus node fails.

The AV node and the His bundle are supplied in 90% of the cases from the right coronary artery and in 10% of the cases from a branch of the left circumflex artery. The right coronary artery supplies most of the inferior and posterior areas of the ventricular myocardium. It is understood, therefore, why an acute heart block occurs mainly as a complication of inferior or posterior myocardial infarction. If, at some stage of injury, the AV node develops increased automaticity, it may assume pacemaking function, particularly if there is concomitant failure or depression of the sinus node. Since nerves and ganglia are numerous near the AV node, the bradycardia and other vagal phenomena, commonly noted during acute inferior myocardial infarction, are most likely caused by reflexes originating in such intracardiac neural centers.

The significance of an arrhythmia varies. Often, it is transient and of short duration causing no symptoms. At other times, arrhythmias may lead to disturbances of circulatory efficiency, and lesser arrhythmias may lead to death-producing ones. Angina, dyspnea, dizziness and syncope, congestive heart failure, hypotension, and cardiac arrest may be the result of arrhythmias.

Sinus bradycardia in an infarcted heart causes reduction in cardiac output, and may be associated with a variety of escape rhythms. It may also be the precursor of more intense vagal discharge, which may then lead to complete heart block or cessation of sinus activity. Sinus tachycardia, unless the heart rate is rapid enough to impair cardiac output, is not of great concern. The possibility of early heart failure should, however, be carefully excluded. Heart block of any degree in the presence of acute myocardial infarction is a bad sign, even though the chance of permanent block among survivors is small. First and second degree AV block sometimes progresses to third degree AV block, and is often associated with a high risk of other arrhythmias, including ventricular tachycardia and fibrillation. If the administration of Atropine eliminates the block, the vagal component is probably the major factor in its pathogenesis. Otherwise, local ischemia of the AV node and the His bundle are the major problems.

Two thirds of the cases of complete heart block occur in the first 24 hours post infarction. If the patient recovers from the myocardial infarction, the complete heart block disappears in most cases. Complete heart block is usually associated with inferior myocardial infarction. However, in about 25% of the cases, the complete block is due to anterior myocardial infarction. In these cases, the block is usually due to bilateral bundle branch block. The death rate is generally higher in cases of advanced and complete heart block associated with acute anterior myocardial infarction. Similarly, mortality appears to be higher in cases of complete heart block in which there is an idioventricular pacemaker with a wide QRS complex, as opposed to a QRS complex of normal duration and configuration.

Multifocal beats, bigeminy, or the imposition of a premature beat on the T wave of a preceding beat are more significant than unifocal beats. They usually precede ventricular tachycardia and ventricular fibrillation. Therefore, quick treatment of premature ventricular beats is necessary. It has been stated by Lown that when ventricular premature beats are controlled by continuous administration of an anti-arrhythmic drug, ventricular fibrillation can be almost completely prevented. It has been observed, however, by studying initial severity of expir-

memory loop electrocardiographic tracings, that ventricular fibrillation can occur soon after the appearance of a single premature ventricular beat.

Having an understanding of the incidence, pathogenesis, and significance of the various arrhythmias associated with acute myocardial infarction is of great importance for the proper therapeutic approach.

REFERENCES

1. Herrick, J. B.: Clinical Features of Sudden Obstruction of the Coronary Arteries, *JAMA* **59**:2015, 1912.
2. Masters, A. M.; Dack, S.; and Jaffe, L.: Disturbances of Rate and Rhythm in Acute Coronary Thrombosis, *Ann Int Med* **11**:735, 1937.
3. Pantridge, J. F., and Geddes, J. S.: A Mobile Intensive Care Unit in the Management of Myocardial Infarction, *Lancet* **2**:271, 1967.
4. Meltzer, L. E., and Kitchell, J. R.: Incidence of Arrhythmias Associated With Acute Myocardial Infarction, *Progr Cardiovasc Dis* **9**:50, 1966.
5. Day, H. W.: Acute Coronary Care—A Five Year Report, *Am J Cardiol* **21**:252, 1968.
6. Lown, B. et al: Unresolved Problems in Coronary Care, *Am J Card* **20**:494, 1967.
7. James, T. N.: *Anatomy of the Coronary Arteries*, New York: Paul B. Hoeber, 1961.
8. James, T. N.: The Coronary Circulation and Conduction System in Acute Myocardial Infarction, *Progr Cardiov Dis* **10**:410, 1968.

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

Baltimore's most unusual dining place!

Famous **Owl Room**



Belvedere Hotel
Charles & Chase Streets

BLOOD PLAN
of the
METROPOLITAN WASHINGTON
BLOOD BANKS, INC.
Not For Profit
A BLOOD DONATION TODAY
PROTECTS YOU AND YOUR
FAMILY TOMORROW

- A Medically Supervised Blood Benefit Program
- Individual—Family—Group Memberships

T. A. Loosbrock, Exec. Dir.
915 19th St. N.W., Suite 500 Phone 737-0060
Washington, D.C. 20006

MERCEDES-BENZ

Baltimore's only Authorized Dealer for Sales, Service and Parts

R. & H. Motors, Inc.
4810 Belair Rd. 426-9200
Baltimore, Md. 21206

Insurance For The Doctor

PROFESSIONAL LIABILITY*

Workmen's Compensation	Fire Insurance
Equipment Floater	Disability Income
Bonds on Employees	Term Life Insurance
Public Liability	Pension Plans

* *Endorsed by MEDICAL SOCIETY OF D. C. & MD.*

Russell, Marsh & Kennedy, Inc.
5151 WISCONSIN AVE. WASHINGTON, D. C. 20016 244-7600



Next time they say they couldn't get you over the weekend... tell them where they can go!

Free! • VALUABLE EXCUSES • Free!

and how to make them sound legitimate.

Check any of the following tried and true alibis which you would like to have substantiated, and we'll send you our Hotel Hershey brochure with all the ammunition.

☐ I WAS SITTING UP WITH A SICK FRIEND. Sick about that terrible hook he'd developed on the back nine. I helped him drown his sorrows in the Iberian Lounge.

☐ I HAD TO GO TO MY GRANDMOTHER'S FUNERAL. Twenty-three years ago. Then last week we had a ball splashing around the pool at Hotel Hershey.

☐ I WAS ONE OF THE SPEAKERS AT A MEDICAL CONVENTION. All I said was "Fore!", but they all listened. No place like Hershey's 72 holes for meeting AWOL medics.

☐ I WAS CALLED OUT ON A MISSION OF MERCY. My wife was dying to get away for a couple of days to Hotel Hershey, where the food is superb and she doesn't have to fix it.

☐ I HAD THIS IRRESISTIBLE COMPULSION TO HIDE. And what could be more secluded than those bridle paths and wooded riding trails around Hotel Hershey . . . gorgeous at this time of year.

☐ I DIDN'T KNOW IT WAS LOADED. The first time I went to Hotel Hershey, that is. Loaded with all good things of life that make even a few days a luxurious vacation. But man, did I ever come back there fast, once I'd found out!

Yes, please send me your brochure.

NAME_____

ADDRESS_____

HOTEL HERSHEY

Hershey, Pennsylvania 17033

One of the Great Resorts of North America



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Business and Pleasure

Since last month's issue of the journal appeared, your librarian has covered quite a bit of territory, partly attending professional meetings and partly vacationing.

With the International Congress on Medical Librarianship convening in Amsterdam early in May, it was possible to continue traveling with the tour arranged by the Medical Library Association (US and Canada). Before leaving Holland, we visited Marken, Volendam, The Hague, Rotterdam, and other points of interest nearby. Then we flew to London for a week of sightseeing and theatre-going, including an all-day trip to Stratford on Avon for a beautiful production of *Winter's Tale*.

After London came Paris and the Scribe Hotel where we experienced our first hotel employee's strike and had the strange duty of making up our own room. But for this, however, it was a delightful hotel and most conveniently located—maybe *too* convenient to expensive restaurants and shops.

Paris was interesting, the food good, but could not surpass the Dutch cooking once we found the better restaurants. The first thing we needed to learn was to interpret traffic signs, else we found ourselves in the midst of onrushing swarms of small, noisy, sports cars. Everywhere, there were droves of bicycles, especially in Amsterdam and Paris; one didn't dare walk on the bicycle paths between the streets and walkways.

To go back to the congress, though, which was the real purpose of this trip, we arrived about 9 am after breakfast aboard the KLM plane, spent some time waiting for baggage for 150 persons, then out to the RAI Congress hall where we joined lines of other librarians already registering. By now, it was almost noon, and with no lunch, we stood till after 5 o'clock in order to register for the Congress, be assigned to a hotel, and *finally* pay for our hotel lodging before we were allowed to leave. This seemed, to say the least, very poor planning on the part of the committees. Unfortunately, this part of the process was handled by a travel organization, *not* the librarians.

After everyone finally adjusted to the loss of five hours and several meals en route, the Congress itself got off to a good start on Monday. Prince Bernhard welcomed the assemblage along with the various members of the Organization Committee, composed of representatives from many countries. The principal social events of the conference were the reception at the impressive Rikjsmuseum on Tuesday evening and an evening at the HET Nationale Ballet. Lacking were the usual planned banquet, and luncheon and dinner meetings for the attendants. This would have been impossible for a group this large.

Reviewing the program, it proves almost impossible to select papers which were most significant, though some stand out more vividly than others, such as one of the last papers delivered—Survey of work in Africa, presented by S. O. Falayi, from the Library of the College of the University of Lagos, Lagos, Nigeria. He drew a vivid picture of the lack of facilities, funds, book collections, information centers, *and* librarians to adequately solve their information problems.

Proceedings of the Congress are scheduled to appear in the fall of this year, and at intervals there will be references to other papers on this page.

* * * * *

Baltimore Hospital Librarians Association will again sponsor a program on medical libraries, especially hospital and nursing, at the Maryland-D.C.-Delaware Hospital Association in Washington, December 2, 1969.

* * * * *

Medical Library Association meeting will be held at the Brown Hotel, Louisville, Kentucky, October 26-30, 1969.

* * * * *

NEW ACCESSIONS—BOOKS
(arranged by author and title)

American Academy of General Practice. Commission on Education
Graduate education for family practice. Kansas City, American Academy of General Practice, 1969.

Atlas, Donald Herman
Reversible renal insufficiency: diagnosis and treatment. Baltimore, Williams & Wilkins Co., 1958.

Baronofsky, Ivan D.
Atlas of precautionary measures in general surgery. St. Louis, Mosby, 1968.

Bauer, Mary Lou
Characteristics of persons with diabetes, United States, July 1964-June 1965. Washington, U.S. Public Health Service, 1967.

Bloom, Samuel William
The doctor and his patient: a sociological interpretation. New York, Free Press, 1965.

Ebony
The Negro handbook, compiled by the editors of Ebony. Chicago, Johnson Pub. Co., 1966.

Goldman, Mervin J.
Principles of clinical electrocardiography. 4th ed. Los Altos, Calif., Lange Medical Publications, 1962.

Guthrie, Helen Andrews
Introductory nutrition. St. Louis, Mosby, 1967.

Hirsch, Edwin Frederick
Frank Billings: the architect of medical education, an apostle of excellence in clinical practice, a leader in Chicago medicine. Chicago, 1966.

Hoagland, Robert J.
Infectious mononucleosis. New York, Grune & Stratton, 1967.

Kelly, James E.
Total loss of teeth in adults, United States, 1960-1962. Washington, Public Health Service, 1967.

Lynch, Henry T.
International directory of genetic services, May, 1968. New York, National Foundation—March of Dimes, 1968.

McGuff, Paul Edward
Surgical applications of laser. Springfield, Ill., Thomas, 1966.

Matthiessen, Poul Chr.
Infant and perinatal mortality in Denmark. Washington, Public Health Service, 1967.

Mountcastle, Vernon B.
Medical physiology. 12th ed. St. Louis, Mosby, 1968.

Muntwyler, Edward
Water and electrolyte metabolism and acid-base balance. St. Louis, Mosby, 1968.

Pratt, Richard Thomas Charles
The genetics of neurological disorders. London, Oxford University Press, 1967.

Progress in neurological surgery. V. 1.
Chicago, Year Book Medical Publishers, 1966.

Quint, Jeanne C.
The nurse and the dying patient. New York, Macmillan, 1967.

Rosenthal, Helen
Diabetic care in pictures: simplified statements with illustrations prepared for the use of the patient. 4th ed. Philadelphia, Lippincott, 1968.

Schakelford, Richard T.
Diagnosis of surgical disease. Philadelphia, Saunders, 1968.

Toxicity bibliography. V. 1.
Washington National Library of Medicine, Jan. 1968

U.S. Public Health Service. Architectural, Engineering and Equipment Branch.
General standards of construction and equipment for hospital and medical facilities. Washington, GPO, 1967.

Wepman, Joseph M.
Recovery from aphasia. New York, Ronald Press Co., 1951.

Winters, Robert Wayne
Acid base physiology in medicine: a self-instruction program. Cleveland, London Co., 1967.

Wohl, Michael Gershon
Modern nutrition in health and disease: dietotherapy. 4th ed. Philadelphia, Lea & Febiger, 1968.

Do Your Patients Need Nursing Service?

Call **889-5666**

COBB-WOODS SERVICES

Vera Woods, M. A. Director

2213 St. Paul St. Baltimore, Md. 21218

Licensed by the State of Md.

MANUEL SCHWARTZ

HEARING REHABILITATION

321 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201

DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION

Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor



A Service of the Tuberculosis Association of Maryland

tuberculosis

COURSE AND PROGNOSIS OF CHRONIC OBSTRUCTIVE LUNG DISEASE

A prospective study was undertaken to identify factors of importance in the prognosis of chronic obstructive pulmonary disease. Ventilatory capacity, resting heart rate, carbon dioxide levels, and the physician's assessment were the most useful indices.

A group of 200 patients with chronic obstructive lung disease were enrolled in a prospective study designed to document the course and prognosis of the condition. Patients accepted for the study were admitted to the hospital for initial and yearly follow-up examinations. At quarterly intervals they were also asked to fill in questionnaires.

The data obtained reflect the course of chronic obstructive lung disease under conservative and individualized medical management, rather than the natural history of the disease. At the end of one year of follow-up, 186 patients were alive. At the end of seven years, 35 were alive, 104 were known to be dead, and four were lost to follow-up. The over-all mortality was 50% before six years. The variables anaylzed were correlated with survival at three and five years. Initial characteristics found not to be significantly related to prognosis included age, sex, race, socioeconomic factors, sputum characteristics, bullae, and axis deviation on the electrocardiogram.

In determining three-year prognosis, the most useful indices were ventilatory capacity, resting heart rate, evidence of cardiac disease, measurements relating to hypercapnia, and physician's assessments of disease severity. Forced expiratory volume in one second (FEV_1), maximum voluntary ventilation, and maximum midexpiratory flow rate were also useful. Less useful were vital capacity (VC), FEV_1/VC ratio, diffusing capacity (D_1), and ratio of residual volume to total lung capacity or nitrogen washout curve. A prominent R wave in Lead V_4R was the most important electrocardiographic finding. Residual volume, total lung capacity, and history of dyspnea were not closely related to survival.

Only two deaths occurred among 31 patients with FEV_1's of 1.15 liters or more and resting pulse rates below 78 per minute. This was a lower mortality than expected for a normal population of the same age. However, there were but three survivors among 26 patients who had FEV_1's below 0.75 liter and pulse rates above 90 per minute.

In simple regressions, change in FEV_1 over two years did not correlate with subsequent survival, apparently because of the tendency of patients with the highest initial FEV_1's who have an excellent prognosis, to show the greatest decline in FEV_1. When initial FEV_1 was held constant in a multiple regression analysis, changes in FEV_1 over two years added significantly to the prediction of subsequent mortality. Thus, the course of expiratory slowing was a useful guide to prognosis if considered in conjunction with the initial FEV_1 level. The observed rate of change in diffusing capacity was also significantly related to subsequent survival when initial FEV_1 was held constant.

A multiple regression analysis that took into account observed changes in variables over two years, in addition to initial observations, indicated that the

atory slowing, the initial heart rate, and the rate of decline of expiratory flow rate were independently useful in prognosis. Consideration of these three features reduced the apparent prognostic value of other observations to insignificant levels.

Course of Findings

Most objective findings showed a systematic worsening with time in surviving patients. The FEV_1 appeared to fall approximately 75 ml per year, and courses of patients were more uniform than expected. At this rate the disease would need to progress for 20 to 30 years before ventilatory impairment became severe enough to produce clinically significant dyspnea. Once mild chronic dyspnea had developed, the expectation would be progression to severe disability from six to ten additional years. These durations are compatible with the clinical histories obtained from patients with the disease and suggest that the disease must begin quite early in life, perhaps even in childhood. An onset of disease in childhood is also suggested by the finding of early emphysematous changes in the lungs of teenagers dying of accidents or trauma.

It appears that the impression that chronic obstructive lung disease is a variable and unpredictable disorder with fluctuating abnormalities is the result of three things: the relatively small yearly changes in pulmonary function tests, the tendency of clinicians to remember exceptional cases, and the optimistic attitude of both patients and physicians.

Prognosis may be simply estimated as having clinical usefulness as follows:

With mild to moderate expiratory slowing (FEV_1 more than 1.15 liters) five-year expectancy is near normal in uncomplicated cases and close to 66% in patients with evidence of cardiac disease or tachycardia at rest.

With moderately severe ventilatory impairment (FEV_1 of 0.75 to 1.15 liters), there is a 66% five-year survival, but this figure is reduced to 33% if evidence of cardiac disease, tachycardia at rest, hypercapnia, or a very low pulmonary diffusing capacity is also present.

With very severe expiratory slowing (FEV_1 less than 0.75 liter), only 33% of patients without complications survive for five years, and five-year survival is unusual if there are any adverse features.

The relation of smoking habits to the course of the disease is difficult to assess. Patients who had stopped smoking before entering the study had a poorer survival than those who continued to smoke cigarettes, but this was related to a tendency of patients to stop smoking when their disease became severe.

Therapeutic Implications

There is a general tendency for the disease to worsen, and this trend becomes increasingly evident as patients are followed for a prolonged period. This generally unfavorable course should not be used to justify a nihilistic attitude toward therapy. There is little doubt that symptomatic relief may be obtained in many patients with severe hypoxemia and cor pulmonale or with recurrent acute exacerbations, but the gradual deterioration of most patients with chronic obstructive lung disease is not prevented by currently available therapy.

BENJAMIN BURROWS, MD, and RICHARD H. EARLE, MD. *The New England Journal of Medicine*, February 20, 1969.

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery MU 5-3232

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202



WHEN YOUR PATIENTS NEED NURSING CARE

Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED
24 HOUR SERVICE ESTABLISHED 1935
BALTIMORE, MARYLAND 21229

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

New Sanitary Enforcement Program

A new Sanitary Enforcement Program has been established by the City Health Department in an effort to prevent further deterioration of city neighborhoods.

In this program, 34 uniformed personnel under the direction of John F. Block, Chief of the Division of Sanitary Enforcement, will serve 124,000 dwelling units and other properties, chiefly in outer city areas. The inner city is now under attack by the Department's Rat Eradication Program. Together, in time, both programs will provide a continuing surveillance of potentially hazardous environmental conditions throughout the entire city and the direction of citizen efforts for their correction or elimination.

The program is the result of recommendations of the Special Summer Sanitation Committee organized by William Donald Schaefer, President of the Baltimore City Council, and chaired by Councilman William J. Myers. Last year, this committee recommended a comprehensive city-wide educational and enforcement program to eliminate and prevent the recurrence of unsanitary conditions in the city. The new enforcement program will help meet this need and also fill the void created by the elimination of the sanitary police division of the Police Department.

In the new attack on this old problem, sanitary enforcement officers will provide comprehensive person-to-person education of the public to eliminate exterior unsanitary conditions and to maintain improved environmental conditions.

Education for correction will be applied to the following: Unsanitary conditions for yards and vacant lots, high grass and weeds, improper refuse disposal, minor rat and insect infestation, unsanitary conditions caused by birds and animals, dilapidated exterior structures, unsanitary vacant structures, defective drainage on private properties, streets, and alleys, and all other problems of exterior environmental sanitation.

In addition to the education program, the City Health Department enforcement personnel have the power under existing city ordinances to carry out the program without any delegation of authority to some other agency. Close cooperation, however, will be maintained with the Department of Housing and Community Development, the Bureau of Consumer Services, the Bureau of Utilities Operations, and the Baltimore Police Department.

Preliminary Results

In a preliminary 14-week period of field duty, begun March 1, over 166,400 inspections were made, over 14,400 notices were given out, and 17 court summonses were issued. In addition, instructional talks have been presented to neighborhood and civic groups by Mr. Block and other staff members.

With this favorable beginning, the Division of Sanitary Enforcement should prove to be an effective new tool in improving the city's environment. Its focus on education, self-help, and pride in a clean city will strongly complement and reinforce the new Clean City Crusade now underway by the Department of Public Works and cooperating agencies.

Area Offices

The four areas served and their chief administrative offices are as follows:

DOWNTOWN DISTRICT Baltimore & South Sts.

W. A. Henderson, Principal Sanitarian
752-2000, Extension 793
7 Enforcement Officers

SOUTHERN DISTRICT 1211 Wall Street

Henry Caplan, Principal Sanitarian
727-3471, Ext. 1
9 Enforcement Officers

NORTHWEST DISTRICT 3006 W. Cold Spring Lane

Henry Lokstein, Principal Sanitarian
752-2000, Extension 631 and 632
9 Enforcement Officers

NORTHEAST DISTRICT 5227 York Road

John Gaskins, Jr., Principal Sanitarian
752-2000, Extension 2872 and 2874
9 Enforcement Officers

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

F.T.D.

Geo. **RADEBAUGH** *& Sons*

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300

Book Reviews

GENETICS AND COUNSELING IN MEDICAL PRACTICE, Reisman, and Matheny; The C. V. Mosby Company, St. Louis, 1969.

By providing a broad coverage of genetic information, this book hopes to aid the family physician in advising his patients. With this in mind, the authors have tried to orient their discussions of genetic disorders to the topics and questions most likely to arise in genetic counseling. To some extent, then, this book is a manual (or perhaps a primer) for genetic counseling in medical practice —not an exhaustive treatise on medical genetics.

ORGANIZATION AND ADMINISTRATION OF HEALTH CARE, Durbin and Springall; The C. V. Mosby Company, St. Louis, 1969.

The title of this book may be misleading, for it is primarily directed at the hospital system we know today in America. It is intended to convey to all those in the health field the necessity for the application of business and administrative techniques to hospital management.

The authors are innovative and persuasive in their arguments, as well as responsive to a great need in an enormously important sector of our national effort. Great stress is placed on the use of systems analysis and computers.

In addition, judging from the text of the book, the authors believe a complete reorganization of the administratve structure of hospitals should take place. Their suggestions range from business and finance to improved patient care.

While theory may be great insofar as it goes, the actual changing of existing patterns will take a long time to accomplish.

THERAPEUTIC RADIOLOGY: RATIONALE, TECHNIQUE, RESULTS, Moss and Brand; The C. V. Mosby Company, 1969.

The third edition of this book has resulted in many revisions, and the addition of illustrations and current concepts.

The book does not claim to be a recipe nor an encyclopedia of radiotherapy. It is designed to serve as an introduction to certain selected clinical problems in therapeutic radiology which, in turn, will lead to improved patient care. Practical

answers are given to practical questions.

This book is a must for all medical libraries, particularly those associated with the teaching of radiology.

HANDBOOK OF PEDIATRIC CARDIOLOGY, Krovetz, Gessner, and Schiebler; Harper & Row, New York, 1969.

This book has been written in recognition of the confusion which may overcome the medical student in his first encounter with the study of congenital heart disease. In order to help him discern between an almost endless variety of possible anomalies, the book has emphasized the fundamentals of pediatric cardiology. It curtails its comments on rarer anomalies while dwelling on the more common disease entities.

General practitioners, pediatricians, and medical students especially, may find this a useful book to add to their reference libraries.

POST-TRAUMATIC PULMONARY INSUFFICIENCY, Moore, et al; W. B. Saunders Company, Philadelphia, 1969.

Perhaps the most interesting facet of this book is its subject matter: patients in the prime of life. In an effort to discover the processes ultimately responsible for the death of young patients who are healthy and socially effective prior to injury (terminal mechanisms in salvageable patients), the authors have presented their observations with a series of longitudinal studies of critically ill patients. The studies were initiated in the summer of 1963.

As the authors themselves say, "It is our purpose to bring together the many facets of patients we have studied, and so to assemble the clinical syndrome as it is seen in patients after resuscitation from tissue injury."

SYMPOSIUM ON THE SPINE, American Academy of Orthopaedic Surgeons; The C. V. Mosby Company, St. Louis, 1969.

As indicated by the preface, the source material for this monograph was taken from the presentations made by the faculty of the continuing education course entitled "Current Concepts on Management of Disease and Injury Involving the Spine." The Symposium was held in 1967, and included such specialties as orthopaedic surgery, neurosurgery, neurology, general surgery, internal medicine, physiatrics, radiology, and general practice. The faculty included those contributions on the "back" which have influenced current diagnostic and therapeutic trends.

It serves as an excellent review of "back" problems for all interested physicians.

NOW

A NEW CONCEPT

in

BOOKEEPING

and

TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

FEDERATED BUSINESS SERVICES, INC.

Box 580
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

On the Hospitalization of Drug Addicts

A record 316 admissions with a diagnosis of drug addiction were reported last year by Maryland's mental hospitals. An additional 26 were admitted for acute drug intoxication. These 342 admissions by 314 persons, in most cases, involved a single treatment episode. Their distribution by race, sex and number of admissions during the year is shown in the following table.

	TOTAL	WHITE MALE	WHITE FEMALE	NONWHITE MALE	NONWHITE FEMALE
NUMBER OF ADMISSIONS	342	126	39	138	39
NUMBER OF PERSONS ADMITTED	314	115	39	126	34
1 ADMISSION	289	105	39	115	30
2 ADMISSIONS	22	9	—	10	3
3 ADMISSIONS	3	1	—	1	1
RATE*	14.0	11.8	3.9	73.2	19.2

Of these 314 persons admitted, 78.1% lived in Baltimore city, 76.8% were male, 83.6% were less than 35 years of age, 71.9% were single, separated, or divorced, and 64.6% reported no previous hospitalization in a psychiatric facility. Proportionally, admissions were in the ratio of six to one between nonwhite and white males and five to one between nonwhite and white females.

Although the Department collects data on drug abuse or dependency of all patients, the 524 cases reported last year probably represent an underenumeration, since this may not be recognized or noted in each instance. Of these 524 patients, 100 were users of two or more specified drugs. The major categories noted were narcotics—386, depressants—125, stimulants—62, and hallucinogens—48. That is, more than three fourths were stated to be users of narcotics, primarily heroin.

As with alcoholics, successful treatment is difficult since it requires complete withdrawal, motivation necessary for continued abstinence, development of constructive influences, and resolution of underlying factors related to the problem. In the United States the most noted treatment facilities are maintained by the National Institute of Mental Health at Lexington, Kentucky, and Fort Worth, Texas. They have reported that only a small proportion of former patients manage to abstain from drugs for any extended time period.

Ultimate efforts to minimize the number of addicts are dependent on a two-fold program for the prevention of new cases and the successful treatment of present users. The former depends on continuing efforts to determine the addictiveness of various drugs, to reduce available supplies, and to resolve socio-economic and psychological factors relating to initial drug use. The latter requires the development of closely coordinated treatment and aftercare services involving public and private agencies, as well as organized groups of former users such as, Addicts Anonymous and Synanon.

** Number of persons admitted per 100,000 estimated population 18 years of age or older in specified race-sex group.*

Better Emergency Care Sought for Highway Crash Victims

Improved in-hospital emergency treatment of highway crash victims is the aim of a new educational program to be launched by the American College of Surgeons, with financial assistance from the Insurance Institute for Highway Safety.

Dr. William Haddon, Jr., Institute president, announced today that a $15,000 grant had been made to enable the College's Committee on Trauma to undertake the program. The College is matching this amount and also will seek additional funding to expand the program.

Beginning with three eight-week educational projects for physicians to be conducted by members of the College of Surgeons in several parts of the country in rural areas, the program will be expanded nationwide. A majority of deaths from highway injuries result from crashes occurring far from urban medical centers.

"As physicians and surgeons know, emergency medical care needs, whether on-site or in the hospital, have too long been neglected by the highway safety movement," said Dr. Haddon. "It is gratifying that the College of Surgeons is taking this step to improve the treatment of the injured."

In accepting the Institute grant, Dr. John Paul North, director of the College, said: "The Committee is conducting nation-wide educational activities to improve the immediate care and transportation of the injured before they reach hospitals. The College now wants to broaden its trauma program by including emphasis on the closely related in-hospital emergency treatment of the injured.

"At this time there is no organized, comprehensive program of continuing medical education for physicians in emergency life-saving measures for critcally injured highway crash victims. Particularly no program exists to provide such education for physicians in their home communities and in the environment of the hospitals in which they practice."

The new program will be under the staff direction of Dr. Oscar P. Hampton, assistant director of the College for trauma activities.

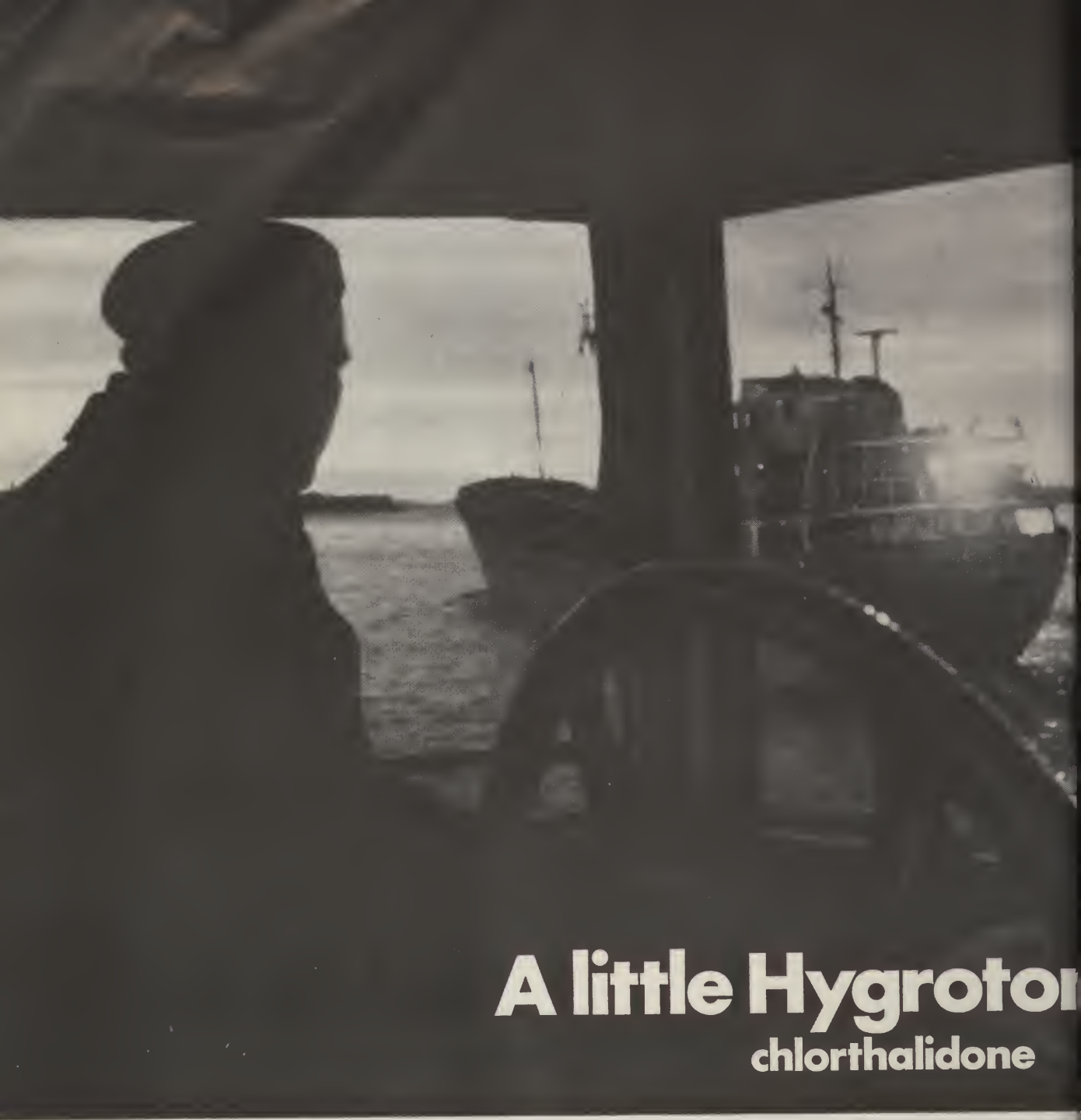
"Comprehensive curricula will be developed for a series of weekly or twice-a-week educational sessions," Dr. Hampton said. "On-site instructional courses will be given by teams of surgeons from the College's Committee on Trauma, or from its state and provincial committees on trauma, to physician-students from the surrounding areas. Visual and printed educational aids will supplement the instruction."

Chairman of the Committee on Trauma of the American College of Surgeons is Dr. Curtis P. Artz, professor of surgery and chairman of the department of surgery, Medical College of South Carolina, Charleston.

LDG
LUCAS DESIGN GROUP

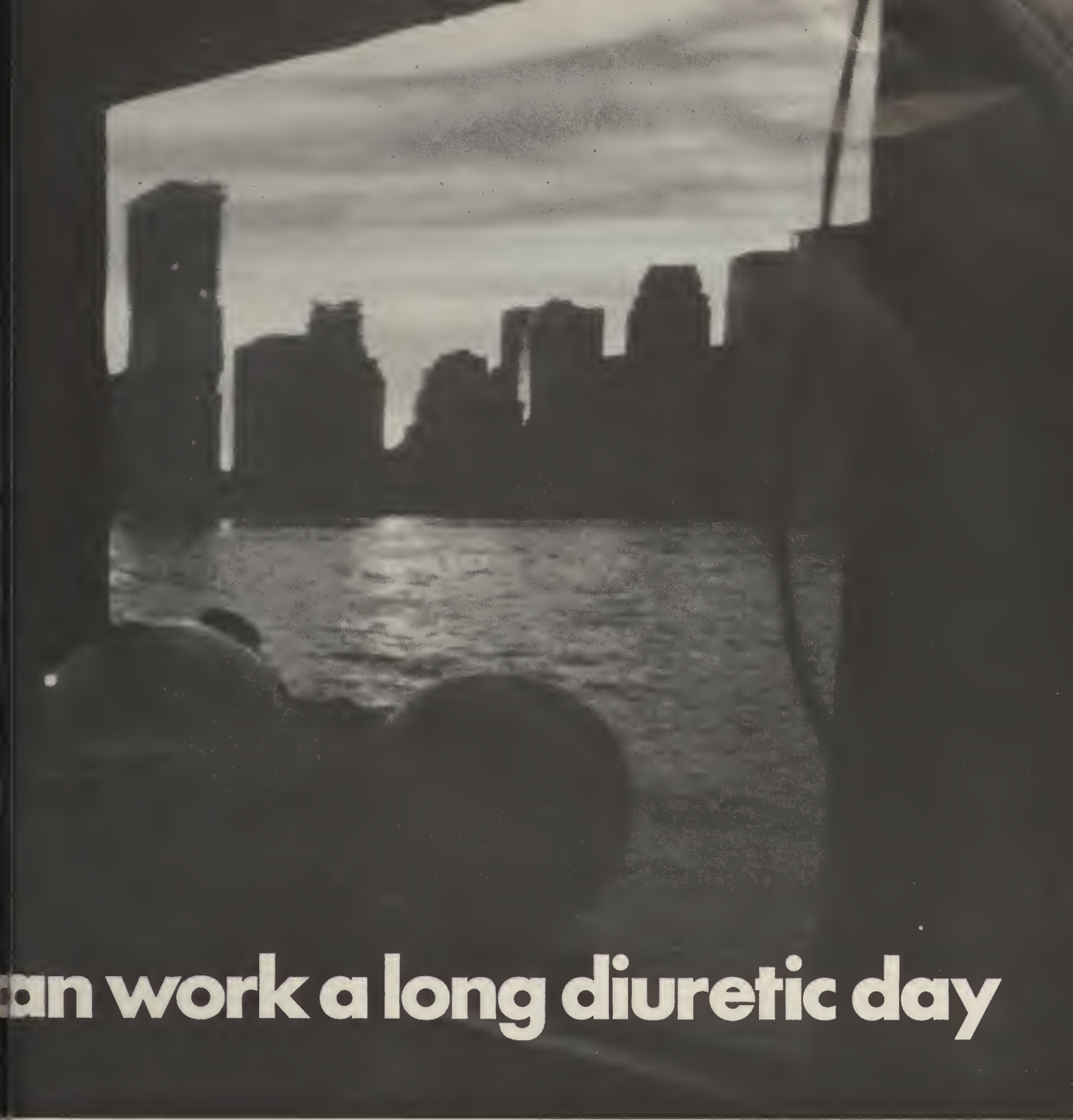
Contract Interior Design Division of Lucas Bros., Inc.
221 East Baltimore St. ■ MU 5-3000

Achromycin V
250 mg. capsules
ACHROMYCIN® V
TETRACYCLINE HCl Lederle
481C-9



A little Hygroton

chlorthalidone



an work a long diuretic day

he way from one daily tablet to the next
elp control edema and hypertension

rolonged action usually provides smooth, sustained diuretic
ctiveness; real one-a-day dosage, right from the start; convenience
economy.

roton, chlorthalidone, can cause side effects. And it's contra-
cated in hypersensitivity to the drug and severe renal and
atic diseases.

ck the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angiitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000.

(B)46-230-E

For full details, please see the complete prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

HY-6674

Baltimore County Medical Association

A dinner was held at the Dobb's House in Catonsville on Wednesday, June 18, 1969.

Mrs. Roger Windsor, President of the Woman's Auxiliary, was introduced, and stated that through the generosity of the doctors, the Auxiliary is able to present a Nursing Scholarship each year. She then introduced Mrs. Delmas Caples, Chairman of the Scholarship Selection Committee, and Miss Paula Mugowski, the recipient of the scholarship. Miss Mugowski graduated from Overlea High School and will enter the School of Nursing at the Church Home and Hospital this fall.

The Rev. Oscar Carlson, Pastor Emeritus of the Ascension Luthern Church in Towson, was introduced. He spoke of his experiences while serving aboard the S. S. Hope. The S. S. Hope is considered a "People to People" Program in which volunteer physicians, nurses, and allied personnel serve two months without compensation. The ship stays in one port for ten months, but there must be a medical school within 25 miles before the ship can dock. The idea was conceived by the late President Eisenhower when the government lent a ship known as the U. S. S. Consolation, which, since then, has been renamed the S. S. Hope. This is the only interest the government has taken in this project.

Every doctor, nurse, etc. who serves aboard the ship must have a counterpart in the country in which the ship is working. Rev. Carlson brought some very colorful and interesting slides showing the ship and the country that he visited.

Following Rev. Carlson's discussion, the business meeting was called to order.

AD Hoc Committee to Study Family Life and Sex Education

James Drinkard, MD, Chairman, reported that the committee studied in depth the materials to be used in the program, teacher preparation, teacher characteristics, and other areas of inquiry that the committee considered pertinent. Three meetings were held, and Dr. Benjamin Ebersole and Mrs. Mary Satterlie from the Department of Education were present at the last meeting. The committee was assured that the films, "Boy To Man" and "Girl To Woman", will be shown to segregated groups of boys and girls, that the boys will see their film and vice versa, and that these films are intended to be a final review of the course. Considerable concern was generated by the statement in the film, "Boy To Man", that masterbation is not harmful. The committee was assured that such a statement would be preceded by formal didactic teaching to the effect that no physical harm may be done by masterbation, but that excessive masterbation may indicate emotional problems. The committee recommended parental involvement in an informational and advisory capacity.

Teacher preparation was discussed at considerable length. Teachers who plan to begin the sixth grade pilot program will soon begin their preparation in the summer workshop. The committee reviewed the qualifications of the advisors to the teachers and found them quite acceptable. The education officials assured the committee that those summer workshops will be open to medical consultants and parents. The Board of Education officials are attempting to plan the classes so that they may be attended by the principal, vice principal, or someone from the Department of Education who is knowledgeable in this field. The board officials assured the committee they would be glad to listen to suggestions from the PTA's of the various schools. In general, the plan is to have the assigned sixth grade teacher as the instructor. Dr. Ebersole suggested the following guidelines that will be strictly adhered to: (1) Individual school principals must approve the teacher; (2) All teachers will be instructed in the basic information necessary to teach the course; (3) Teachers must be of proven competence, ie, there will be no first year teachers; (4) All teachers must have at least their Bachelor's degree; (5) All teachers must have already worked in health education; (6) All teachers must have demonstrated proficiency in working with students individually; (7) All teachers in this course will have their references closely reexamined; (8) Supervision will be closer in this field than any other, as outlined above; and (9) If no competent teacher is avaliable, there will be no course in Family Life and Sex Education.

By a four to three vote, the committee passed the following resolution: If the question of premarital relations is raised by a pupil, and if in the judgment of the teacher further discussion is necessary, we strongly recommend that possible adverse effects of such premarital relations be included in the discussion.

The committee concluded its work with the unanimous passage of the following motions:

1. This committee approves of the proposed sixth grade pilot program in Family Life and Sex Education—with the Recommendations aforecited.
2. An advisory committee of no less than five members of this association shall be established to act in an advisory capacity to the Baltimore County Board of Education and Baltimore County School Officials.

The members of the committee were John Snyder, MD, Barbara Solomon, MD, Ramsay Thomas, MD, Frank Kasik, MD, John Krager, MD, John Gibbs, MD, and James Drinkard, MD. Dr. O'Donnell and Dr. Reese attended the meetings as consultants.

Dr. Reese moved that the report of the ad hoc committee be received. Motion was seconded and carried.

Dr. O'Donnell introduced the following resolutions:

"The Baltimore County Medical Association, having carefully studied the instructional materials in the Baltimore county sixth grade pilot program in Family Life and Sex Education, and having received free assurance from the responsible Baltimore county educators of their plans to:

1. Separate boys and girls during sensitive instructional times
2. Involve the parents in both informational and advisory capacity
3. Select, train, and supervise the teachers with great care
4. Teach the course in a family-life ethical framework
5. Request the Baltimore County Medical Association to appoint a committee to advise and guide the Baltimore County Board of Education in the medical and psychiatric aspects of Family Life and Sex Education

Does hereby give its endorsement and approval to the program.

The Baltimore County Medical Association requests Dr. Gibbs to act as the original chairman and appoint a committee of no less than five members for society endorsement to advise and guide the Baltimore County board of education in their Family Life and Sex Education Program. This committee to serve until the annual meeting of 1971, by which time the Bylaws Committee shall have incorporated such a committee in the Bylaws as a standing committee with provisions for change, yet continuity of membership."

After an in depth discussion, the resolution as proposed, was passed with only one dissenting vote.

There being no further business, the meeting was adjourned.

John M. Krager, MD
Secretary-Treasurer

WOMEN OF ALL AGES

Train for a rewarding career as

MEDICAL ASSISTANT

- Short, comprehensive course in day or evening classes prepares you fully for this challenging and well-paid profession. Modern, air-conditioned classrooms with the finest equipment. Highly competent faculty. Free placement service for our graduates.

Approved by Maryland State Dept. of Education

DOCTORS....

OUR INTERNSHIP PROGRAM

offers you the services of a trained assistant for post graduate internship without salary obligation.
Call or write for full details.

MARYLAND ACADEMY OF MEDICAL & DENTAL ASSISTANTS

Executive Two Bldg. 32 West Road
Towson, Maryland 21204

Phone: **821-5222**

Growing Feet Can Have Problems!



PRONATION KNOCK-KNEES PIGEON-TOES

These common problems can be helped with proper shoes, correctly fitted.

Prescriptions Carefully Filled

VAN DYKE & BACON

307 N. Charles St. SAratoga 7-3775
5849 York Rd. IDlewood 3-1100
Baltimore, Maryland

CLINICAL CENTER STUDY OF HEMOLYTIC ANEMIA

The cooperation of physicians is requested in the referral of patients for studies of idiopathic auto-immune hemolytic anemia being conducted by the National Institute of Health, Bethesda, Maryland.

Referrals of patients with Coombs' positive idiopathic auto-immune hemolytic anemia are needed. Also, selected patients with secondary types of auto-immune hemolytic anemia, especially of the cold antibody type, will be accepted. Preference will be given to patients who have not received previous treatment.

Studies will be performed to determine the type of antibodies involved and the role of complement in hemolysis. Following this, patients in need of therapy will be treated, and experimental drugs may be used. All patients will be carefully followed during the course of the study. On completion of their studies, patients will be returned to the care of the referring physician who will receive a summary of findings.

Physicians interested in having their patients considered for admission to these studies may write or telephone.

Michael M. Frank, MD
or
John S. Sergent, MD
Clinical Center, Room 11-N-104
National Institutes of Health
Bethesda, Maryland 20014

Telephone: 496-4964
(Area Code 301)

DOCTORS' OFFICES

LARGE
MEDIUM
SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST.
CORPORATION
11 E. Chase St.
Phone 539-8553

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL
SAVINGS AND LOAN ASSOCIATION
ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE
DIRECT REDUCTION HOME LOANS
Hours 9 A.M. to 2 P.M. Daily
Tuesday Evenings 7 to 9
355-9300
PATAPSCO AVENUE & FOURTH STREET
Baltimore, Maryland, 21225

Convalescing . . . but still a long way to go. Anxiety can make it even longer.

Convalescence following medical or surgical procedures may be almost endless to an anxious patient. And, indeed, anxiety with some patients actually retards progress—for example, by inducing insomnia and reducing cooperation.

As physicians have found during nearly 15 years of widespread use, Equanil may be a beneficial part of aftercare. It helps relieve anxiety and tension, thus often aiding your primary therapy.

Indications: For use in management of anxiety and tension occurring alone or as accompanying symptom complex to medical and surgical disorders and procedures. Though not a hypnotic, fosters normal sleep through antianxiety and related muscle-relaxant properties.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

EQUANIL®
(meprobamate)

Wyeth®

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.



IN BALTIMORE.....

House In The Pines Nursing Homes have the facilities and experience to care for those you care for



HOUSE IN THE PINES
NURSING HOMES

PROFESSIONAL CARE FOR THE AGED, CHRONICALLY ILL AND CONVALESCENT.

• Bright, pleasant surroundings and a home-like atmosphere • Fire-safe accommodations • Competent professional care, 24 hours a day • Complete Physical and Occupational Therapy facilities and programs under the direction of our licensed staff therapists

• Modern kitchens supervised by licensed staff dietitian provide tasty, balanced meals.

BEL AIRE — 5837 Belair Road — CL 4-8800
BELVEDERE — 2525 W. Belvedere Ave. — FO 7-9100
CATONSVILLE — 16 Fusting Ave. — RI 7-1800
also Easton, Md., Rt. 50 & Dutchman's Lane. TA 2-4000

YOUR INSPECTION INVITED • BROCHURE ON REQUEST

One Surgeon's Views On Fixed Fee Dilemma

One of the great dilemmas of American surgery today is the issue of the fixed professional fee versus a fee based on each surgeon's own increasing costs. It's a controversial subject, one on which the general public is little informed and on which surgeons themselves do not always agree.

In the letter below, Richard L. Meiling, dean of the Ohio State University College of Medicine, spells out the essentials of the situation as well as anyone ever has. It was written, originally, in response to a question concerning Medicare and its financial aspects put to Dr. Meiling by Robert M. Zollinger, chairman of the American College of Surgeons Communications Committee. It is being reprinted here solely for the information of the Fellows, and in no way reflects official College policy. Nor does it represent any official action by the Board of Regents.

Dr. Meiling, formerly, served as Director of Medical Services, Department of Defense, from 1949 through 1951.

"In my opinion, what is actually happening is that you're talking about (1) patient fees and patient-physician relationship; and (2) a highly-technical, economically-oriented insurance industry.

"These are two very separate questions. If you take the insurance program and Medicare as being developed as an indemnity program, the individual has to be paid and the industry, itself, has to pay taxes. In most instances it is not a nonprofit organization, and yet everybody agrees that the industry, per se, has the right to all these perquisites, costs, labor costs, etc., in the administration of an indemnity program.

"Now, as to the patient, the fee, and the physician. Congress in its great wisdom, or in its lack of same, has said that everyone over the age of 65 shall be treated the same regardless of financial status or the patient's desire for private room, private nurses, etc. It's hard to put in words the fact that if you used fixed fee schedules, the physicians or dentists or druggists who will make money on this basis are not necessarily the best qualified nor members of the group delivering the best type of health care.

"I don't think the Board of Regents can solve this problem. And any delightful platitude which they wish to give would probably be accepted by the membership and the public, depending on the public relations presentation of this platitude.

"You come right down to the basic reality that the surgeon or physician is, in fact, an industry; he has labor costs, insurance costs, etc., that have increased tremendously in the past several years, so his usual and customary fee is going to have to increase proportionately to cover the increased costs of doing business.

Nobody questions this in the insurance business because as labor costs, taxes, etc. increase premiums are increased.

"On the other hand, the surgeon is expected to do his surgical procedure at the same price he did it 20 years ago, notwithstanding the fact that he may be paying 300% more for his office nurse and his office secretary, 600% more for his insurance and liability coverage, and 800% more for his rent of office, his parking and his car.

"I would hope that some high group, the Board of Regents or some other group, would begin to show what these costs are. For example, the increase in professional liability from $200 to $800 in three years, or the increase from $300 per month for a secretary to $1000 per month in many instances today. I can remember when an office could be rented for $1.80 per square foot. The same space costs $6.50 today.

"The problem is to present to the public exactly what's involved in a professional fee. The public thinks of this fee as a fee for service, and this service is personal. They have no appreciation of what it costs every morning for that surgeon to leave his home and begin the delivery of personal care. Before he steps out of the house he must pay income tax and surtax, city income tax, state taxes, liability insurance, life insurance, group insurance, the salary of a secretary and an office nurse, the rental liability protection of his office space and his equipment, his automobile and gasoline taxes; all of this, plus his continuing education in the field of his specialty, before he's taken that first step out of his front door. This is the way business approaches the cost of a product. Now, it costs so much to market that product; and in our society it is reasonable to expect amortization of costs, maintenance of buildings, replacement of equipment, education of personnel, endowment programs, etc., which the purchaser must pay before he gets the item being sold. On all of this there must be a profit margin.

"If it were possible to present this in either animation or actual living movie, maybe Congress and the

public would understand why medical fees and surgical fees are not and cannot be what they were "x" number of years ago. Likewise, if you go to a program with "fixed fee schedules" then medical groups, in all probability, would go bidding for patients in a manner similar to which a bank or insurance company bids for municipal or school bonds. The public will get, then, exactly what they pay for; no more and no less. It may be good, it may be poor and, like many products they buy every day, it may be fragile and breakable; but until the medical porfession is able to present its side of the story, we'll have trouble."

BALTIMORE OXYGEN SUPPLY CO., INC.

OHIO CHEMICAL DISTRIBUTORS

Therapy and Medical Gases
and Oxygen Tents
Resuscitators and Apparatus

Main Office & Plant: Linthicum, Md. 789-8100
Warehouse: 1611 Guilford Ave., Baltimore, Md. 727-4748
Branch: 2426 Linden Lane, Silver Spring, Md. 582-2094

Visit the #1 Spot for Your Diet Needs

Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)

For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic

SPECIAL DIET SHOP
Phone SA 7-0383

COLOSTOMY
ILEOSTOMY

Appliances and Disposable Bags

CALL
FIELDS PHARMACY
IN PIKESVILLE
for convalescent supplies and service

FOR RAPID DELIVERY 486-3300

Advertisement

AN ANNOUNCEMENT TO MARYLAND PHYSICIANS WHOSE PATIENTS HAVE CHRONIC SLEEP DISTURBANCE

Recent advances in sleep research have made it possible to measure a variety of sleep disorders in otherwise normal patients.

To further these studies a clinic is being established at the Maryland State Psychiatric Research Center under the direction of Dr. Clinton Brown, Chief of Basic Sciences Research.

The primary purpose of this clinic will be to investigate the variables producing insomnia so that more effective treatment approaches may be formulated.

Of interest are: 1) the personality configuration, 2) sleeping habits and 3) psychophysiologic reactivity of the patient with chronic complaints of inability to fall asleep, frequent or early awakenings, somnambulism, enuresis or nightmares.

Individuals accepted for study will be given a physical exam, interview, psychometric test and polygraph recordings obtained during sleep.

Patients will be accepted by referral only and a diagnostic report will be furnished to the referring physician at the conclusion of the study.

Partial support for this project is being furnished by Friends of Psychiatric Research, a non-profit research foundation. While fees will not be charged, voluntary contributions by patients to offset study costs will be welcomed.

Additional information or appointment may be obtained by calling Mrs. Zaborowski at 744-8700, Ext. 252, 10 A.M. to 4 P.M. Monday thru Friday.

Albert A. Kurland, M.D., Superintendent.

SKILL SURGICAL, INC.

SUPPLIES & EQUIPMENT
for
PHYSICIANS–SURGEONS
HOSPITALS

5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

Why not let CHERNOCK guard your valuable key records in their modern, safe, fireproof warehouse.
Surprisingly inexpensive.

CHERNOCK
MOVING and
FIRE PROOF STORAGE

PHONE 685-7630

CLINICAL CENTER STUDY OF CYSTINOSIS

The cooperation of physicians is requested in the referral of patients with cystinosis to participate in studies being conducted by the National Institute of Arthritis and Metabolic Diseases at the Clinical Center, National Institutes of Health in Bethesda, Maryland.

Of particular interest are pregnant women who are mothers of cystinotic patients. There is reason to believe that in-utero diagnosis of cystinosis can be achieved. Thus we are especially interested in studying women, as early in pregnancy as possible, who are at risk for giving birth to a cystinotic child.

Physicians who wish to have their patients considered for these studies may write or telephone.

Jarvis E. Seegmiller, MD
or
Joseph D. Schulman, MD
Clinical Center, Room 8-D-19
National Institutes of Health
Bethesda, Maryland 20014

Telephone: 496-4781
(Area code 301)



For your next meeting, banquet or convention . . . consider



THE NEW OCEAN CITY
CONVENTION HALL

One of the most beautiful facilities on the east coast—ideal for sales meetings, private parties, banquets, conventions, trade shows . . . concerts, dances and sporting events. Will accommodate up to 2000 at a banquet, 3000 at a convention; meeting rooms for 50 to 300 persons. Air-conditioned and heated—for year-round use. Large private parking area.

For complete information . . . . write
EARL G. BAIRD, *Executive Director*
4000 Philadelphia Ave., Ocean City, Md. 21842

Ocean City, Maryland

For Fun and Frolic

Mario's
Specializing in
ITALIAN ★ AMERICAN FOOD
CONTINUOUS ENTERTAINMENT IN OUR INTIMATE Cocktail Lounge
Phone AT 9-9445
OCEAN CITY, MD.

The BIG One On The Ocean
Ocean City, Md.
Stowaway
MOTEL
21st to 22nd St. & BOARDWALK

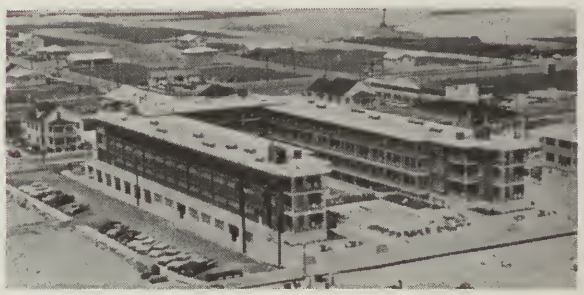


"The Stowaway Has Everything"

- One full block of beautiful beach
- Air Conditioning • Free Parking
- 120 Units, 33 Efficiencies
- Children's Pool • Color TV Room
- Magnificent Olympic-size Pool
- Restaurant and Cocktail Lounge
- Free TV in every room • Supervised Beach
- European Cuisine

For Reservations—Call ATlantic 9-6191

DIPLOMAT MOTOR HOTEL



Largest, Most Luxurious Units on Beach
Bedroom and Efficiency Units
• CONTINENTAL CUISINE •
Food Prepared by our Chef for the Most Discriminating Connoisseurs
100% Air Conditioned

- Swimming Pool
- Dining Room
- Cocktail Lounge
- Coffee Shop

. . . and you get TV in every room

WE CATER TO CONVENTIONS – *Accomodations for small groups, up to 300 persons*

Boardwalk at 26th W
Telephone 289-7148
OCEAN CITY MARYLAND

Advertisers in This Issue

A & F Nurses Registry 41
Aids for Hearing, Inc. 58
Arundel Federal Savings & Loan Assoc. 111
Baltimore Nurses Exchange (Alice Weber) 100
Baltimore Oxygen Supply Co., Inc. 116
Belvedere Hotel 95
Bolton Hill Dinner Theatre 41
Bristol Laboratories 65
Broadview Restaurant 43
Burroughs Wellcome & Co., Inc. 40
Capital Savings & Loan Association 95
Oscar Caplan & Sons 8
Chernock Moving and Storage Co. 117
Club Venus 43
Cobb-Woods Services 98
Coca Cola Bottlers 32
Cork 'n Bottle Restaurant 43
Diplomat Motor Hotel 118
Doctors Supply Company 55
Eleven East Chase St. Corp. 111
The Evangelical Press 58
Fedder's Medical Services 8
Federated Business Services, Inc. 103
Fields Pharmacy 116
Franklin Uniform Co. 34
Geigy Pharmaceuticals 106-108
Hecht Co. Northwood Rooftop Restaurant 43
High Fidelity House 55
Highland Hospital 33
Hilton Nursing Home ..... 3rd Cover
Hood Convalescent Home 64
Hotel Hershey 96
House in the Pines Nursing Homes 114
Hynson, Westcott & Dunning, Inc. 1
Kelly Pontiac 35
Key Circle Hospice Nurs. Home 91
Lederle Laboratories 2, 58, 59, 64, 105, 117
Eli Lilly & Co. 4
Lucas Brothers 105
Maico Hearing Aids, Inc. 41
Maria's 300 Restaurant 43
Mario's Restaurant 118
Maryland Academy of Medical & Dental Assistants 110
Maryland Psychiatric Research Center 116
Medical Personnel Pool 30
Mercantile-Safe Deposit & Trust Co. 17
Metropolitan Washington Blood Banks, Inc. 95
Miller Brothers Restaurant 43
Milton Inn 43
Monarch Lincoln Mercury 30
Murray-Baumgartner Surg. Instr. Co., Inc. 11
National Drug Co. 15-16, 92
Ocean City Convention Hall 118
Palmer House Restaurant 43
Parke, Davis & Co. 68
Chas. Pfizer & Co., Inc., Pfizer Laboratories Division, Bonine 18-19
Pitman-Moore 60-61
T. Rowe Price Growth Stock Fund, Inc. 57
Professional Management Co. 11
Professional Systems & Services, Computer Center, Inc. 12
Geo. Radebaugh & Sons 102
Read's Drug Stores 55
R & H Motors, Inc. 95
A. H. Robins Co. 62-63
Roche Laboratories ..... 36-39, 4th Cover
Wm. H. Rorer, Inc. 7
Russell, Marsh & Kennedy, Inc. 95
Security Savings & Loan—a Stock Corp. 57
Manuel Schwartz, Hearing Rehabilitation 98
G. D. Searle & Co. 66-67
Skill Surgical Instrument Co., Inc. 117
Special Diet Shop 116
Sterling Lighting Co. 41
Stowaway Motel 118
Stuart 14
Mano Swartz—Furs 8
Taylor Manor Hospital ..... 2nd Cover
Therapeutic Appliances, Inc. 58
Tijuana Tacos 43
Town & Country Motors 64
Twentieth Century Auto Radio & TV 41
Van Dyke & Bacon—Shoes 110
Ventnor Marine Service 55
D. Stuart Webb Advertising Services, Inc. 100
Westview Lounge & Supper Club 43
White Rice Inn 43
Wyeth Laboratories 112-113
Zimmermann's Shoes 8

Classified Advertising

POSITIONS AVAILABLE

INTERNISTS—(General Medicine) for a 765-bed GM&S hospital and 550-bed Domiciliary; affiliated with George Washington Univ.; low-cost housing and excellent receational facilities available; within easy driving distance of Washington, D.C. and Baltimore, Md. An equal opportunity employer. Apply: Chief of Staff, VA Center, Martinsburg, West Virginia 25401.

PARTNERSHIP, GP—Modern two-doctor office building; well-equipped. Good country; congenial people. Baltimore-Washington area. Salary or percentage first year. Retiring in 2-3 years. Open staff hospitals available. Adequate time off. Details appreciated in reply. Write: Box #16, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

EMERGENCY ROOM PHYSICIANS—Membership in Group Practice. Guaranteed minimum income $30,000. Include complete curriculum vitae in reply. Address to Haluk Boneval, MD, Chief, Emergency Room Service, Prince George's General Hospital, Cheverly, Md. 20785. Telephone: 301-341-3041.

FOR RENT

MEDICAL OFFICES—Beautifully panelled suites containing five examining rooms. Located in Dundalk, adjoining Charlesmont Apts (600 units), and many other homes. Urgently need GP, surgeon, pediatrician, and others. Reasonable rental. Call: 285-3400, Dr. Oken.

OFFICE SPACE—In new professional building in Havre de Grace. Write: Box #17, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

LARGE OFFICE—Space available in a suite with over 600 sq. ft. Two independent entrances, 5 rooms including 3 consultation rooms, staff room, and a waiting room. Also a bath. Suite is located in a most modern Medical Building with ample parking facilities, and next to the North Arundel General Hospital. Write: Box #18, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201; or call: 761-0619.

FOR SALE

COMPLETE CONTENTS OF ORTHOPAEDIST OFFICE—2 desks and other furniture, physical therapy equipment, instruments, file cabinets, treatment tables, etc. Contact: Philip O. Pelland, MD, 5610 54th Ave., East Riverdale, Md., or phone: 298-7294.

ESTABLISHED MEDICAL PRACTICE INCLUDING BUILDING AND EQUIPMENT—Ideal for group. Reasonable—to settle estate. Call: 727-0033 (Baltimore).

CLASSIFIED ADVERTISING

Effective May 1, 1963

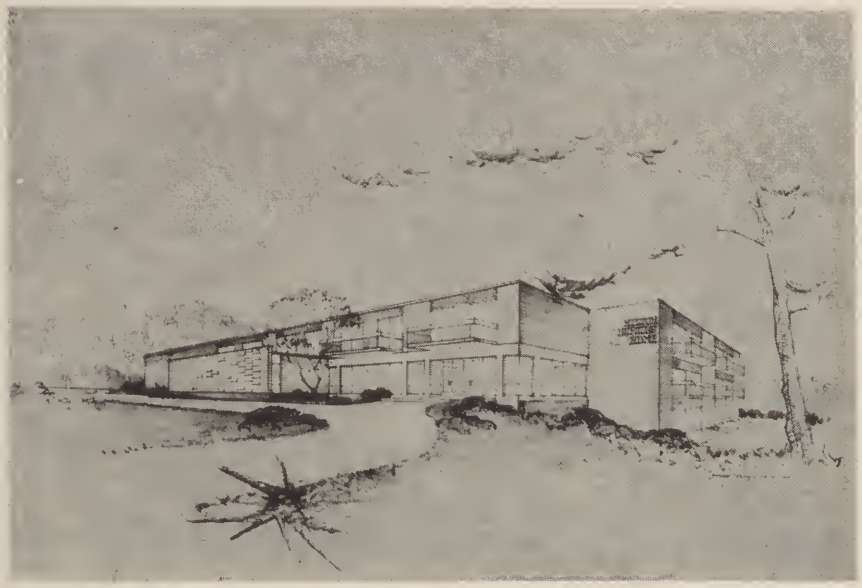
$1.50 per line per insertion

Count seven average words to each line. Add one line if box number is desired.

Members of the Medical and Chirurgical Faculty shall be entitled to one complimentary insertion in any twelve-month period. Widows of members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment.

MARYLAND STATE MEDICAL JOURNAL
1211 Cathedral St., Baltimore, Md. 21201

Opening 1969



HILTON NURSING HOME

3313 Poplar Street, corner of Hilton

4 blocks south of North Ave. & Hilton St.

BALTIMORE

Now being built—a superb new 104-bed facility, the last word in pleasant living and competent care for the aged, ill or convalescent. Embodying the highest standards and the most advanced equipment and luxurious furnishings, it will meet your most exacting requirements.

Modern, air-conditioned and fire-safe building

Finest facilities for comfort and health care

104 beds, all in private and semi-private rooms—no wards or dormitories

Registered nurses 24 hours a day

For advance information . . . . phone

426-3104



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

W1
MA791

MARYLAND
STATE MEDICAL JOURNAL

VOLUME 18 NUMBER 9
SEPTEMBER, 1969

NATIONAL LIBRARY OF MEDICINE
RECD. OCT 1969
INDEX
INPUT

JTC: LJY
INDEXER:
VOL-ISS: 18-9
DATE:
PAGES:



How much does illness and lost time cost you?

KEX FLOOR PLAN PACKAGE —SERVICED BY RENTEX— IS EFFECTIVE AGAINST INFECTIOUS GERMS!

Read this Important News Now: — The U.S. Dept. of Agriculture has accepted the following claims for KEX Services:

- "KEX" Walk-Off-Mats are chemically treated with an anti-microbial additive to inhibit the growth and spread of environmental bacteria in a mat and to reduce contamination in the areas serviced by Walk-Off-Mats.
- "KEX" Walk-Off-Mats are effective against Staph Aureus.
- "KEX" Walk-Off-Mats reduce populations of air and dust-borne Staph Aureus in the areas serviced by Walk-Off-Mats.
- "KEX" Walk-Off-Mats reduce the introduction of bacterial populations in rooms serviced by Walk-Off-Mats.

Help clean the air for you and your employees. Let your Rentex Service expert show you how to minimize air borne bacteria with KEX Services. Act Now — TODAY! Call CE. 3-5700.

RENTEX SERVICES CORP.

RENTEX EASTERN OVERALL DIVISION

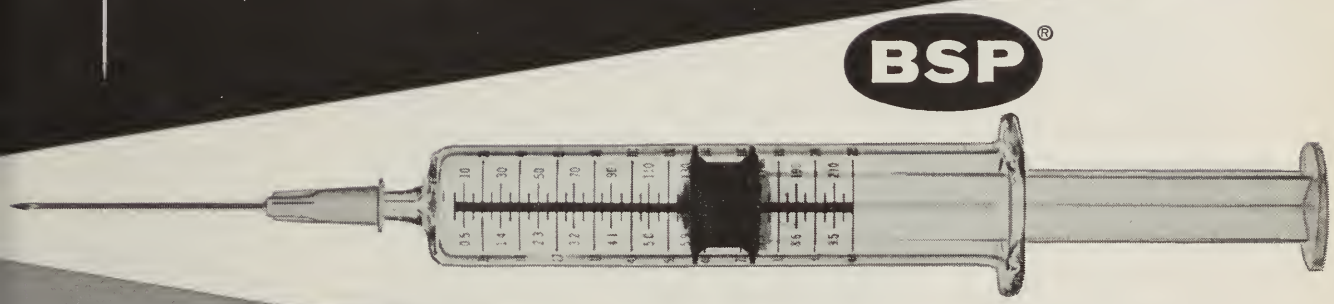
2804 WILKENS AVE., BALTIMORE, MD. 21223 • CE 3-5700

EASTON, MARYLAND ALEXANDRIA, VA.

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

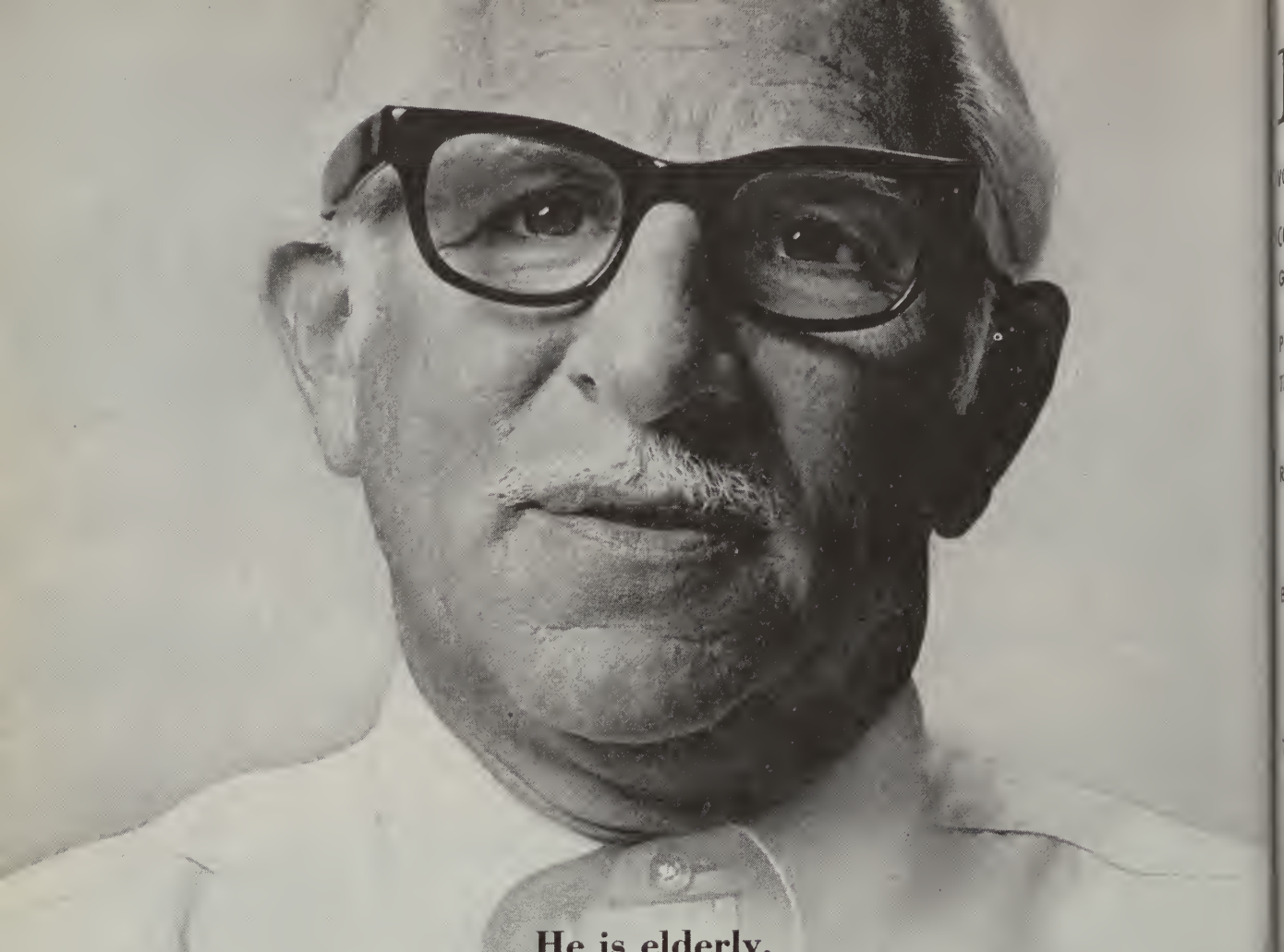
The all-inclusive BSP Disposable Unit provides economic unit dispensing.

Complete literature available on request.

HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(BSP04)



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. C stant observation is essential. If new infections appear, appropri measures should be taken. In infants, increased intracranial press with bulging fontanels has been observed. All signs and symptoms h disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, di rhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculop ular and erythematous rashes; a rare case of exfoliative dermatitis l been reported. Photosensitivity; onycholysis and discoloration of t nails (rare). Kidney—rise in BUN, apparently dose related. Transi increase in urinary output, sometimes accompanied by thirst (rar Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylax Teeth—dental staining (yellow-brown) in children of mothers given t drug during the latter half of pregnancy, and in children given the dr during the neonatal period, infancy and early childhood. Enamel hyp plasia has been seen in a few children. If adverse reaction or idios crasy occurs, discontinue medication and institute appropriate thera Demethylchlortetracycline may form a stable calcium complex in a bone-forming tissue with no serious harmful effects reported thus in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should given 1 hour before or 2 hours after meals, since absorption is impair by the concomitant administration of high calcium content drugs, foo and some dairy products. Treatment of streptococcal infections shou continue for 10 days, even though symptoms have subsided.

Leder

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

345-8

Maryland State
Medical Journal

VOLUME 18 SEPTEMBER 1969 NUMBER 9

CONTENTS:

Guest Editorial—Service Program—American Cancer Society, Maryland Division, Inc., Edward A. Sawada, MD 60

Psychiatry for the Family Physician, William L. Stewart, MD 62

The Drug Issue, Murdock Head, MD 63

"The problems of the inner city are directly related to the environment. A great many of our concerns, particularly in the psychiatric area, are related to the environment. The drug issue is one of these."

Recognizing the Suicidal Patient, Bernard R. Shochet, MD 65

"Depression is a serious systemic disease with psychological and physiological expression, of which suicide is very much a part. The person seriously contemplating suicide does this from a sense of profound despair and feeling of hopelessness. The diagnosis of despair is a difficult and elusive one, and we must listen attentively with 'the third ear' to tune it in. . ."

Behavior Disorders in Children, Ruth W. Baldwin, MD 68

"In the past 20 years, especially in the last five years, much has been written about organic behavior disorders or brain damaged children under some 38 different terms, such as, Minimal Brain Damage, Minimal Brain Dysfunction, Brain Injury, Brain Damage, Hyperkinetic Syndrome, and Percentually Handicapped. Behavior problems, formerly considered emotional ones, are now being recognized as organic in origin. . . . Treatment must be three-prong—medical management with various medications, counselling, and educational planning."

The Adolescent Turmoil, Ghislaine D. Godenne, MD 72

". . . For sake of clarity, one should first define the limits of the adolescent period. Adolescence is a period of life ranging from puberty to adulthood. Although the age of puberty is relatively easy to determine, the one of adulthood is rather vague: one can set it at 18, 21 or 25, 45!—never! Arbitrarily, at The Johns Hopkins Adolescent Clinic, we have set the upper limit of adolescence to 21 years of age—the age at which an adolescent becomes legally independent from its parents. . . ."

Grief and Depression in Old People, Robert D. Patterson, MD 75

"Grief and depression occur to people at all times through their lives, but these conditions are special problems for old age. Much can be done to ease the pain of depression and help people complete their grieving."

Some Medical and Sociological Problems of the Urban Community, M. Alfred Haynes, MD 80

"The major health problems of our cities are essentially the health problems of the poor. The cities contain a large percentage of the rich, but they also contain 54% of the poor. Many of the latter are black, and although the majority of the poor in America are white, the nonwhite are twice as likely to be poor as the white. . . . It is unfortunate to be poor, but to be poor and black is to carry a tremendous burden of increased morbidity and mortality. This is the group which forms the heart of our cities."

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 83

Rehabilitation Notes—Rehabilitation of Patients Suffering From Fracture of the Hip, Parts III & IV, John D. Hsu, MD 85

Maryland State Department of Mental Hygiene—Fact Sheet for Fiscal 1969 . 89

Baltimore City Health Department—Evaluation Service for the Elderly 91

Heart Page—Lipoprotein Phenotypes, Lawrence F. Misanik, MD 103

Maryland State Department of Health—Federal Grant Approved for Family Planning Program 109

Library Page—History of the Library 115

Traffic Safety—Man Against Machine: International Accident Symposium, Susan P. Baker, MPH 121

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301). ©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland. Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

ON THE COVER: This month's cover photo was executed by a young, but promising photographer **W. Brooks Short, III.** Brooks, a Baltimorean, is a student at McDonogh School. Many of you may have seen him on the Faculty premises this summer in the capacity of library assistant. The staff is indebted to Brooks for his contribution to September's issue.

Doctors Take Note **5**
Executive Secretary's Newsletter **9**
Sex Education of Children and Youth **13**
Book Reviews **18**
The Month in Washington **26**
Mental Health of Urban America Reviewed **30**
Baltimore Association of Medical Assistants **31**
Scientific Exhibit Reservation Form **41**
Med-Chi's List of Interpreters **43**
Medical News **46**
Sample Discharge Summaries **49**
Information for Authors **50**
Future Trips for Med-Chi **59**
Woman's Auxiliary **101**
Library Accessions **115**
Classified Advertising **140**
Advertising Index **141**



Will everyone get his fair share?

Uncle Sam doesn't really want more than his share. But he often gets it when someone neglects to make a will. Or when a trust officer and lawyer have never been consulted about the many ways estate taxes may be minimized under today's complicated tax and inheritance laws.

Maryland National's Trust Department is widely experienced in all phases of creating and administering trusts. And we have an investment performance record we'll proudly compare with any other.

So talk with your lawyer. Then talk with us. Just call 685-3900 and ask for Jack Boadway. He and your lawy will help make sure that what you've worked so hard for will keep right or working hard, and that your heirs wi get their fair, and full, shares.

maryland national
TRUST DEPARTMENT

Doctors take note...

SEPTEMBER 17-19, 1969
ENVIRONMENTAL CONTROL ADMINISTRATION

Scientific Symposium—Biological Effects and Health Implications of Microwave Radiation: John Marshall Hotel, Richmond, Va. Contact: Chris A. Hansen, Commissioner, Environmental Control Administration, Bureau of Radiological Health, U. S. Dept. Health, Education, and Welfare, Rockville, Md. 20852.

SEPTEMBER 21-25, 1969
SPECIAL VIRUS CANCER PROGRAM OF THE NATIONAL CANCER INSTITUTE/LEUKEMIA SOCIETY OF AMERICA, INC.

4th International Symposium On Comparative Leukemia Research: Cherry Hill Inn, Cherry Hill, New Jersey. More than 80 papers will be presented by scientists and physicians from throughout the world to more than 500 attendees. Contact: Mr. Art Foley, Director of Public Education and Information, Leukemia Society of America, 211 E. 43rd St., New York, N.Y. 10017.

SEPTEMBER 22, 1969
UNIVERSITY OF MARYLAND SCHOOL OF PHARMACY

Lectures: Geriatric Medicine, W. Grafton Hersperger, MD; and Altered Response to Drugs in the Geriatric Patient, David A. Blake, MD. 7:00-10:00 PM in Dunning Hall, 636 W. Lombard Street, Baltimore. For further information, contact: Peter P. Lamy, PhD, University of Maryland School of Pharmacy, 636 W. Lombard St., Baltimore, Maryland 21201, or phone 955-7593.

SEPTEMBER 24, 1969
UNIVERSITY OF MARYLAND SCHOOL OF PHARMACY

Lectures: Laminar Flow and Sterile Procedures, Peter P. Lamy, PhD, and Alan Jaskulski; and Drug Stability and Storage, Ralph F. Shangraw, MD. 7:00-10:00 PM in Dunning Hall, 636 W. Lombard Street, Baltimore. For further information, contact: Peter P. Lamy, PhD, University of Maryland School of Pharmacy, 636 W. Lombard St., Baltimore, Maryland 21201, or phone 955-7593.

SEPTEMBER 29-OCTOBER 1, 1969
HEART ASSOCIATION OF MARYLAND

3 Days of Cardiology—"Coronary Heart Disease: A Comprehensive Outlook": Peter Bent Brigham Hospital, Boston, Mass. For further information, contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Maryland 21201.

OCTOBER 1-4, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Vascular Disease: Mayo Clinic, Rochester, Minn. Co-directors: Alexander Schirger, MD, and P. J. Osmundson, MD. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

OCTOBER 6, 1969
DISEASE DETECTION INFORMATION BUREAU

International Symposium on Early Disease Detection: Elkhart, Indiana. Chairman: Morris F. Cohen, MD. Registration is open to all physicians, without fee. Forms can be obtained from D. Dib, 3553 W. Peterson Avenue, Chicago, Ill. 60645.

OCTOBER 6, 1969
MARYLAND SOCIETY OF INTERNAL MEDICINE/SECTION OF INTERNAL MEDICINE, BALTIMORE CITY MEDICAL SOCIETY

Fall Joint Meeting: 8:15 PM, Osler Hall, 1211 Cathedral St., Baltimore, Md. 21201. Speaker: Samuel P. Asper, MD, Associate Dean and Professor of Medicine, The Johns Hopkins School of Medicine, President of the American College of Physicians.

OCTOBER 6-10, 1969
COUNCIL ON MEDICAL EDUCATION OF THE AMERICAN MEDICAL ASSOCIATION

55th Clinical Congress: San Francisco. The Congress' program includes 15 carefully planned postgraduate courses and the Forum on Fundamental Surgical Problems, consisting of several hundred research-in-progress reports by young surgeons. Contact: American College of Surgeons, 55 East Erie St., Chicago, Ill. 60611.

OCTOBER 8-11, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Medical Oncology Today—An Internist's Guide to Cancer Chemotherapy: University of Minnisota Medical School, Minneapolis, Minn. Director: B. J. Kennedy, MD, FACP. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

OCTOBER 11, 1969
AMERICAN COLLEGE OF PHYSICIANS

Regional Meeting (Maryland and DC): 8:30 AM, The Johns Hopkins Hospital, Turner Auditorium. All physicians, house staff and students are welcome.

OCTOBER 13-17, 1969
AMERICAN ASSOCIATION FOR LABORATORY ANIMAL SCIENCE

20th Annual Session: Sheraton-Dallas Hotel, Dallas, Texas. Principal speaker: Rep. Paul G. Rogers (D.-Fla.). Among the seminars will be one on "Inutero Surgery as a Research Tool," with Robert L. Hummer, VMD, San Antonio, as moderator. Information on the session, and hotel reservation forms may be obtained from AALAS, P.O. Box 10, Joliet, Ill. 60434.

OCTOBER 15-17, 1969
HEART ASSOCIATION OF MARYLAND

3 Days of Cardiology for Nurses—"Recent Advances in Cardiovascular Nursing": University of Michigan. For further information, contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Maryland 21201.

OCTOBER 16, 1969
FEDERAL BAR ASSOCIATION/BALTIMORE CHAPTER

3rd Annual Federal Tax Forum: Statler Hilton, Baltimore. One-day seminar devoted to professional incorporation—Maryland law, hazard of tax litigation, tax benefits and traps; income, employee benefits and estate planning; transitional problems of changing from partnership to corporation, and procedural steps; what incorporation means to the various professions. Contact: Sylvan H. Sack, Chairman, 2404 St. Paul St., Baltimore, Md. 21218.

OCTOBER 17-18, 1969
HEART ASSOCIATION OF MARYLAND

Annual Meeting: Belvedere Hotel, Baltimore, Maryland 21201. For further information, contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Maryland 21201.

OCTOBER 18-23, 1969
AMERICAN ACADEMY OF PEDIATRICS

38th Annual Meeting: Palmer House Hotel, Chicago, Ill. Subjects will be presented during the meetings of the Sections on Allergy, Anesthesiology, Cardiology, Child Development, Diseases of the Chest, Military Pediatrics, Pediatric Pharmacology, Public Health Pediatrics, and Surgery. For further information, write: Department of Public Information, 1801 Hinman Ave., Evanston, Ill. 60204.

OCTOBER 22-25, 1969
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

District IV Meeting: Shoreham Hotel, Washington, DC. For further information, contact: The American College of Obstetricians and Gynecologists, 79 W. Monroe St., Chicago, Ill. 60603.

OCTOBER 23, 1969
NEW YORK STATE ACTION FOR CLEAN AIR COMMITTEE

5th Annual Symposium on Air Pollution and Respiratory Disease: New York University Medical Center, 550 First Avenue, Manhattan. A review of the present research on the effects of air pollution on health and discussions of future alternatives to some of today's air-polluting practices are included in the sessions. Contact: New York State Action for Clean Air Committee, 105 E. 22nd Street, New York, N.Y. 10010.

OCTOBER 23-25, 1969
AMERICAN COLLEGE OF GASTROENTEROLOGY

Annual Course in Postgraduate Gastroenterology: The Rice Hotel, Houston, Texas. For further information and enrollment, contact: American College of Gastroenterology, 299 Broadway, New York, N.Y. 10007.

NOVEMBER 5, 1969
COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE AND PUBLIC HEALTH, MEDICAL & CHIRURGICAL FACULTY/NATIONAL COMMUNICABLE DISEASE CENTER

Viral Symposium: 9:30 AM-5 PM, 1211 Cathedral St., Baltimore. Program will include virology —advances and horizons; viral exanthems, hepatitis, laboratory diagnosis of viral diseases, respiratory viral diseases, CNS-enteric diseases, rubella, and antiviral agents. Speakers: Maurice A. Mufson, MD, Director of Virology, Hektoen Institute for Medical Research, Cook County Hospital, Chicago; Philip A. Brunell, Assistant Professor of Pediatrics, New York University School of Medicine; Frederich W. A. Deinhardt, MD, Chairman, Department of Microbiology, Presbyterian-St. Luke's Hospital, Chicago; Robert Friedman, MD, Senior Investigator, Laboratory of Pathology, National Cancer Institute, Bethesda, and H. Brandis Marsh, MD, Medical Officer, Respiratory Virology Unit, National Communicable Disease Center. Registration fee: $5 (includes lunch). Contact: Mrs. Ritchie, 1211 Cathedral St., Baltimore, Maryland 21201; (301) 539-0872.

NOVEMBER 14, 1969
THE CHILDREN'S MEDICAL AND SURGICAL CENTER OF THE JOHNS HOPKINS INSTITUTIONS

Conference—Clinical Advances in Pediatrics. Practical aspects of patient care will be stressed, such as, management of jaundice in newborn, diagnosis and treatment of anemia in childhood, and use versus abuse of antibiotics in Pediatrics. For additional information, contact: Matthew Debuskey, MD, The Johns Hopkins Hospital, 601 N. Broadway, Baltimore, Maryland 21205.

Exclusively in Maryland

FUR DESIGNS APPROVED BY WORLD-FAMED

Oleg Cassini

★



Mano Swartz

225 N. HOWARD ST.

MARYLAND'S OLDEST AND LARGEST FURRIER

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED

227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.



Individual Jewelry

We are jewelry *designers,* creating *individual* pieces in our own shop.

Should you desire a custom-made piece of jewlery to symbolize a person or an occasion, consult us without obligation.

We will carry out your ideas or furnish suggestions.

Cost is less than you may imagine because we operate our own shop.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn, Easton, Md. (TA 2-1553)

Inexpensive Effective

CAMP



HEAD HALTER TRACTOR KIT

Recommended for traction treatment of:

1. Syndromes caused by slipped cervical discs.
2. Certain fractures of cervical vertebrae.
3. Certain types of tuberculosis of the spine, in preparation for, instead of or after fusion of the spine.
4. Certain cases of neck-muscle spasm.
5. Temporary measure until a cervical brace is prepared.

DONALD O. FEDDER, ORTHOTIST

Rents and Sells Hospital Equipment

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

executive secretary's newsletter

September, 1969

TAX REFORM AND PROFESSIONAL CORPORATIONS

The Tax Reform bill now before Congress seems to have put a crimp in the trend toward formation of professional corporations. If the tax reform bill is passed as it now reads, professionals who elect to file tax returns under Subchapter S of the IRS laws will not be permitted to deduct expenses for retirement programs that exceed the present Keogh limitations.

However, the Faculty's Med-Chi Insurance Trust is now investigating the possibilities for tax advantageous retirement programs for Professional Corporations not electing Subchapter S treatment. An initial legal opinion from a nationally known tax attorney indicates distinct advantages, even for the solo practitioner, in a corporate structure for his practice of medicine.

Be on the lookout for details of this proposal, scheduled to be made available to members within the near future -- in sufficient time for incorporation in the current year.

LICENSE REVOCATION

The license of Alfred L. Cole, MD, Baltimore, has been suspended for a 60-day period, effective June 30, 1969.

NATIONAL HEALTH SHOW

The National Health Show has been booked into Baltimore's Civic Center from December 4 to December 14, 1969. Full details will be made available to interested parties at a later date.

1970 SCIENTIFIC EXHIBITS

Space is still available for Scientific Exhibits at the Faculty's 1970 Annual Meeting, April 1, 2, 3, being held at The Alcazar. Application forms may be obtained through the Faculty office.

SUMMER RESEARCH PROGRAM

The Faculty's Delegates to the American Medical Association House of Delegates were interviewed during the AMA House meeting in July by medical students from both The Johns Hopkins University School of Medicine and the University of Maryland

SUMMER RESEARCH PROGRAM (cont'd)

The two students, supported by a grant from the U.S. Department of HEW and OEO, were investigating all aspects of the field of medicine other than scientifi ie, socioeconomic, etc. Following the AMA session, both individuals were assigned to a preceptorship with a U.S. Senator or Congressman, newspaper or some other public activity for the remainder of the summer.

CHILD ABUSE COMMITTEE

The State Department of Social Services has reactivited its Advisory Committee on Child Abuse. The Committee was originally established following legislation involving the reporting of suspected child abuse cases with its purpose that of implementation of the legislation. The reactivation of the group is to consider the question of whether the legislation has accomplished its purpose and whether further educational or legislative action is needed.

PROFESSIONAL INCORPORATION FORUM

A Forum on Professional Incorporation is scheduled for Thursday, October 16, at the Statler-Hilton Hotel, Baltimore, from 9:30 a.m. through 4:30 p.m.

Arnold Streich, LL.B., Director, Corporate Law Department of the AMA will be one of the speakers. Registration, including lunch, is $30 per person and may be made through application to the Faculty office.

1970 STATE LEGISLATION

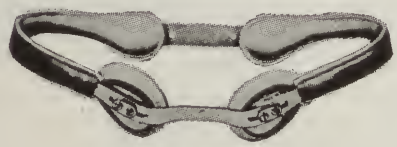
Proposals up for consideration for possible introductio into the 1970 State General Assembly include broadeni of the provisions of the present Parental Consent legislation. The change would authorize physicians to treat, on a psychiatric basis, those students who are over age 18 without obtaining consent of their parents. In addition, discussions are taking place with respect to proposed nurse-midwife licensure; licensure for radiologic technologists, nursing home administrators, and others.

John Sargeant

Executive Secretary

All the newest, improved

SURGICAL APPLIANCES



- Arch Supports
- Cervical Collars
- Abdominal Supports
- Sacro-Lumbar Belts
- Colostomy and Urinary Appliance

COMPETENT, EXPERIENCED SURGICAL FITTERS TO ASSIST YOU

WE RENT and SELL

- WHEEL CHAIRS
- HOSPITAL BEDS
- INVALID LIFTERS
- PUMPS . . . LAMPS

MEDICARE FORMS

We will assist your patients in processing the required Medicare information concerning items purchased or rented from us.



Serving the Medical Profession for half a century

Murray-Baumgartner

SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.

Phone: 669-9300 Baltimore, Md. 21216

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then, PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And free your secretary to be your secretary again.

professional systems and services *division of*

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3886




Darvon®
Compound-65
Each Pulvule® contains 65 mg. propoxyphene hydrochloride, 227 mg. aspirin, 162 mg. phenacetin, and 32.4 mg. caffeine.
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206.
900252

Sex Education of Children and Youth

Currently, there is much discussion and debate about sex education of our young people and, particularly, with respect to sex education in schools. Accordingly, it seems advisable at this time to review the American Medical Association's position supporting sex education for children and youth.

In 1960 at the Annual Convention in Miami Beach, the House of Delegates of the American Medical Association adopted a general resolution on health education in schools and colleges. The resolution reaffirmed "the American Medical Association's long-standing and fundamental belief that health education should be an integral and basic part of school and college curriculums and that state and local medical societies be encouraged to work with the appropriate health and education officials and agencies in their communities to achieve this end." Sex education is generally considered as one aspect of health education.

In 1965 at the Annual Convention in New York City, the House of Delegates of the American Medical Association accepted a progress report of the AMA Committee on Maternal and Child Care on the problems of unwed parents. In this report, the Committee set forth its conviction that "the physician can contribute significantly to preventive aspects of illegitimacy by counseling young patients on sexual attitudes and behavior," and reiterated the position of the AMA's Joint Committee on Health Problems in Education with the National Education Association, regarding 'the school's responsibility to supplement the home and other community agencies in teaching the facts about reproduction, the nature of the sexual drive, and the values inherent in our family system."

Previously, in 1964, the Joint Committee on Health Problems in Education had adopted a resolution delineating this concept and urging schools to ". . . accept appropriate responsibility for reinforcing the efforts of parents to transmit knowledge about the values inherent in our family system, and about the psychic, moral, and physical consequences of sexual behavior . . . that this be done by including in the general and health education curriculum the physiology and biology of human reproduction beginning at the elementary level and continuing throughout the school years at increasing levels of comprehension, and . . . that the concept of the family as a unit of society based on mature, responsible love be a continuing and pervasive educational goal." A year later, the Joint Committee supplemented its 1964 resolution with another resolution pertaining to the role of the physician in sex education recommending ". . . increased emphasis in medical schools and continuing education programs to orient physicians in the area of sexual attitudes and behavior. . . ."

The AMA Committee on Human Reproduction during its deliberations became convinced that improved public, as well as, professional education is an essential ingredient to meeting today's issues concerned with human sexuality. In this regard, the Committee recommended in 1964 that "the AMA take the responsibility for disseminating information on all phases of human reproduction, including sexual behavior, by whatever means are appropriate within the resources of the Association." In 1968, the Committee also recommended that the "AMA provide source material and educational opportunities for school and community health educators to improve their understanding and knowledge regarding human sexuality and family life education."

At its Annual Convention in San Francisco in 1968, the House of Delegates of the American Medical Association approved a number of recommendations concerned with the reduction of infant mortality in the United States. Among these recommendations was one dealing with education as follows: "The American Medical Association should inaugurate and support programs of health education, including good maternal and child health practices, family life and sex education, and the appropriate use of health care resources."

In 1968, a special ad hoc committee of the Board of Trustees of the American Medical Association studied needs in the area of human reproduction. As a result of its deliberations, this Committee reported a series of recommendations about medical school and continuing education programs designed to "assist the physician in dealing with problems of

sexuality in medical practice and in his role as a counselor in family life education." In the same report, the Committee also made a series of recommendations encouraging: ". . . the teaching of human sexuality as a basic aspect of health education in schools and colleges," and the ". . . preparation of teachers properly equipped to handle sex education as a significant aspect of health education." These recommendations were approved by the Board of Trustees in December 1968.

In AMA deliberations relating to sex education, there has been a continuing emphasis on a number of guiding principles that are considered basic to education in this area. Included among these are the concepts that: (1) the basic responsibility for sex education belongs to the home, but the church, school, and some other community agencies have a supplementary role in reinforcing and supporting the efforts of the home; (2) that involvement of broad representation from the community in both the planning and conducting of sex education in schools is essential to acceptable inclusion of this sensitive area in the health education curriculum; (3) that the physician, with a sensitivity to the need for counseling in sex education, can contribute significantly to education of his patients in this area; (4) that those persons involved in supporting the efforts of the home through sex education in churches, schools, and other appropriate agencies must be exemplary individuals who are carefully selected and properly prepared for this important responsibility; (5) that sex education in the schools should be an integral and important aspect of the over-all health education program and not a separate course, project, or program; and (6) that materials of instruction used in sex education must be carefully selected with respect to school and child level placement, general and educational suitability, physiological and psychological accuracy, and appropriateness, and community acceptance in terms of local conditions, customs, and traditions.

The American Medical Association and many other national agencies and organizations concur with respect to sex education for children and youth. Below are listed some of the national groups which have made statements or issued supporting documents on the matter.

American Academy of Pediatrics

American Association for Health, Physical Education, and Recreation

American College of Obstetricians and Gynecologists (Committee on Maternal Health)

American Public Health Association (Governing Council)

American School Health Association

Interfaith Commission on Marriage and Family Life (Synagogue Council of America, U.S. Catholic Conference, National Council of Churches)

National Congress of Parents and Teachers

National School Boards Association and American Association of School Administrators (Joint Committee)

National Student Assembly of the YMCA and the YWCA

Sixth White House Conference on Children and Youth

United Nations Education, Scientific, and Cultural Organization

United States Department of Health, Education, and Welfare (Commissioner of Education)

For a number of years, the Joint Committee on Health Problems in Education has published, and made available at cost, a series of booklets on sex education for children of various ages and their parents. Inquiries to: AMA, 535 North Dearborn Street, Chicago, Illinois 60610 (Box #10).

IN THE BUILDING AND TRADITION OF THE
BALTIMORE EYE EAR AND THROAT HOSPITAL



AT THE FRANCIS SCOTT KEY MONUMENT
Near Jones Falls Expressway and State Office Building

Key Circle Hospice
NURSING HOME & EXTENDED CARE FACILITY
R. W. Hansen, *Administrator*
1214 EUTAW PLACE BALTIMORE, MARYLAND 21217
523-7800
THE BEST CARE AVAILABLE
UNDER CONSTANT MEDICAL SUPERVISION
MODERATE RATES



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

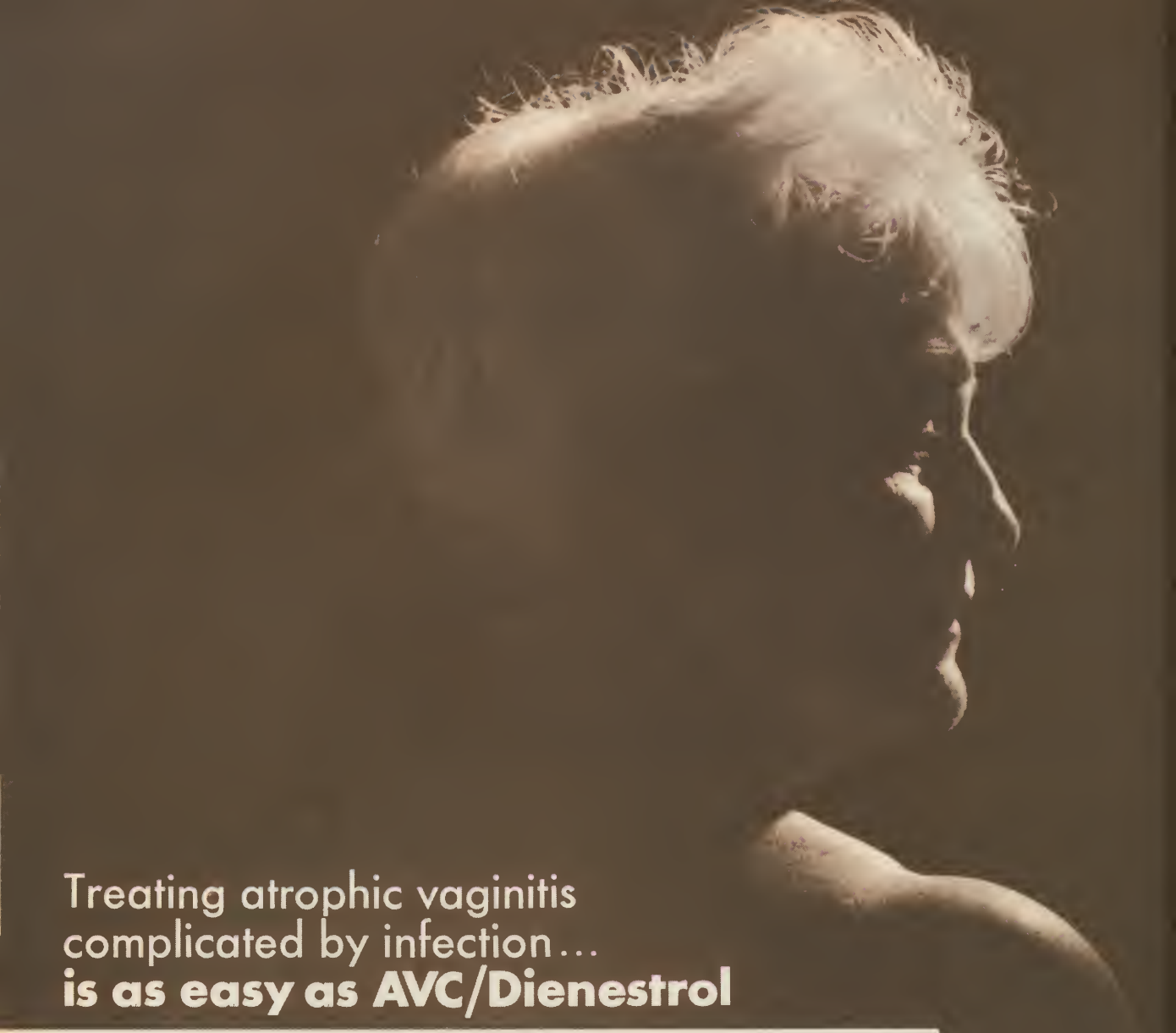
Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps

Q915A 1/70



Treating atrophic vaginitis complicated by infection... **is as easy as AVC/Dienestrol**

Dienestrol helps restore estrogen-deficient vaginal mucosa.
It is the *particular* ingredient in AVC/Dienestrol that improves cell maturation counts[1,2] — helps stimulate the restoration of normal vaginal epithelium to resist infection.

Two recent studies reconfirm AVC/Dienestrol efficacy.[1,2] AVC/Dienestrol is proven effective against monilial, trichomonal, nonspecific bacterial vaginitis, and mixed infections.[1,2] AVC/Dienestrol combats infection, helps restore tissue resistance to reinfection.

So even in complex cases, the treatment can remain the same. Comprehensive. Effective. Easy as AVC/D.

Contraindications: Known sensitivity to sulfonomides; diognosis or fomiliol history of corcinomo of the genitol troct or breosts; precorcinomatous lesions of the vogino or vulvo; polpoble uterine fibromyomo; mommary fibroodenomo; depressed liver function.

Precautions/Adverse Reactions: The usuol precoutions for topicol ond systemic sulfonomides should be observed becouse of the possibility of obsorption. Burning, increosed tocol discomfort, skin rosh, urticoria or other monifestotians of sulfonomide toxicity or sensitivity ore reosons to discontinue treatment. The use of AVC/Dienestrol does not preclude the necessity for coreful diognostic meosures to eliminote the possibility of neoplosio of the vulvo or vagina. Monifestations of excessive estrogenic stimulotion through dienestrol obsorption moy occur. These include uterine bleeding, breost tenderness, exocerbotion of menstruol irregulority and provocation of serious bleeding in women sterilized becouse of endometriosis. Endometriol withdrowol bleeding moy occur if use is suddenly discontinued.

Dosage: One opplicotorful or one suppository introvoginolly once or twice doily.

Supplied: 'AVC/Dienestrol Creom'—Four ounce tube *with* opplicotor. 'AVC' ond 'AVC/Dienestrol Suppositories'—Box of 12 *with* opplicotor.

References: (1) Solerno, L. J.; Ortiz, G., ond Turkel, V.: Voginitis: A Diognostic and Theropeutic Approoch, Scientific Exhibit, presented ot the 115th Annual A.M.A. Convention, Chicogo, Illinois, June 1966. (2) Nugent, F. B., ond Myers, J. E.: Pennsylvanio Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC/Dienestrol

Cream (dienestrol .01%, sulfonilomide 15.0%, ominocrine hydrochloride 0.2%, ollontoin 2.0%)
Suppositories (dienestrol 0.70 mg., sulfonilamide 1.05 Gm., ominocrine hydrochloride 0.014 Gm., ollontoin 0.14 Gm.)

TRADEMARK: A V C

AV-920A 7/69



ANNOUNCING THAT

The GUNDRY SANITARIUM

*Established 1900 * * * Continually Growing and Modernizing*

(1) . . . HAS BEEN ACCREDITED FOR 3 YEARS BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

(2) . . . HAS BEEN CERTIFIED AS A PARTICIPATING HOSPITAL FOR HEALTH INSURANCE UNDER SOCIAL SECURITY (MEDICARE)

The GUNDRY SANITARIUM, a complete psychiatric community, includes a 33-bed Inpatient Hospital for female patients, a Night Hospital for female patients, a Day Hospital for male and female patients, and an Outpatient Department for patients of all ages.

Wouldn't you feel satisfied knowing that your patient is receiving care in a hospital with all these advantages:

- **Treatment is based upon intensive individual and group psychotherapy combined with drug therapy when indicated**
- **All the Doctors are highly trained Psychiatrists**
- **Highly trained Nursing and Medical staff is available 24 hours a day**
- **Environment is warm and homelike.**
- **Protected against fire by approved sprinkler system**
- **Competent medical consultation in all fields is available**
- **Close liaison with the referring physician is maintained**
- **All forms of occupational and recreational activities are offered**
- **Follow-up care in the Day, Night or Outpatient Service**
- **RATES are reasonable; outpatient fees on a sliding scale.**

The GUNDRY SANITARIUM

2 N. WICKHAM ROAD **BALTIMORE, MD. 21229** **Phone 644-9917**

Psychiatric Hospital
licensed by the
State of Maryland

Rachel K. Gundry, M.D.
MEDICAL DIRECTOR

ACCREDITED FOR 3 YEARS BY JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

CERTIFIED AS A PARTICIPATING HOSPITAL FOR HEALTH INSURANCE UNDER SOCIAL SECURITY

5%
special
interest
accounts
$3,000 to $25,000

- ☐ Interest calculated on minimum quarterly balances and credited semi-annually (April 1 and October 1).
- ☐ New Accounts opened by the 10th of any month earn interest from the 1st of the month.
- ☐ Deposits received by the 10th of the first month of any quarter earn interest for the full quarter.
- ☐ Deposits or withdrawals in $1000 multiples may be made at any time.
- ☐ Rate on Regular Savings Accounts . . . 4½% per annum.

you ought
to use Eutaw

EUTAW
SAVINGS BANK

EUTAW AND FAYETTE STS.
AND SIX CONVENIENT BRANCH OFFICES

MEMBER FDIC

Book Reviews

PHYSICAL DIAGNOSIS: THE HISTORY AND EXAMINATION OF THE PATIENT, Prior and Silberstein; Third Edition, The C. V. Mosby Company, St. Louis, 1969.

The authors of this book add a new dimension to their subject—approached from a physiological standpoint—by rooting it in the philosophy that physical diagnosis should be meaningful and practical. It should not be a mere mechanical process, or treated so by the physician or the patient.

Therefore, one of the main objectives of this book is to teach the student how to obtain an adequate history, along with helping him to become a physician. Explanation of medical terminology and discussion of disease is accomplished with simplicity and brevity in order to prevent the student from being overwhelmed by a wealth of material.

So, if you are in need of a textbook on this subject, we highly recommend it.

TOP WATERFOWL GUNNING



CHOPTANK RIVER FARM

83 acres with ½ mile shoreline, sandy beach, deep anchorage: includes small year round house.

Close to Easton, this is a good value at $125,000.

For details contact
HELAINE WHITE, REALTOR
Easton, Maryland (301) 822-4626

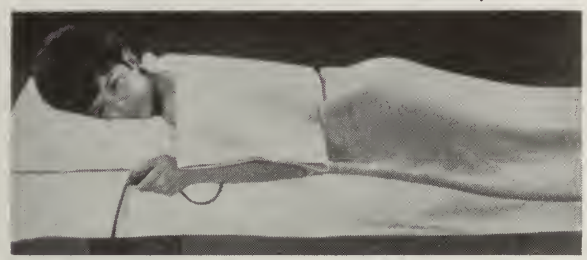
ATLAS OF NUCLEAR MEDICINE: VOLUME ONE, BRAIN, DeLand and Wagner; W. B. Saunders Co., Philadelphia, 1969.

This book literally illustrates one of the most popular procedures in nuclear medicine—the brain scan. By mapping out the distribution of radioactivity within the body, the book shows how various diseases can be detected and localized, eg, cerebral infarcts and hemorrhages, and tumors. Needless to say, one can see the value of this technique in diagnosing diseases.

Nevertheless, the authors do not let the reader take the obvious for granted in their explanation of brain scanning. They substantiate the invaluable use of this method by including numerous pictures of brain scans, accompanied by short studies on each one, consisting of a clinical history, a prior diagnosis, a description of the scan, an interpretation, the subsequent course, and the final diagnosis. In almost every case, the results of the brain scan indicate a prior misdiagnosis.

In conclusion, the book affords the reader a clear and concise understanding and appreciation of the importance of brain scanning, and will be of great interest to anyone connected with this specialty.

Now When You Recommend Moist Heat,



Recommend Automatic Moist Heat.

Until now, application of moist heat required boiling water, hot towels, and somebody to apply them. The Battle Creek THERMOPHORE changes all that. It provides instant and automatic moist heat, intensely hot, deeply penetrating.

The patient simply plugs it into an outlet. This unique hot fomentation pad then generates its own moisture from the air. Intensely hot moist heat is constantly maintained, and evenly distributed throughout the pad. No water is needed, no filling or emptying is required.

Large 13" x 27" pad covers back, or chest and abdomen, or both legs. Safety thermostat turns it off automatically, prevents overheating.

Price is **$35.00.** Also available in medium size 13 x 13 **$25.00.**

Phone for Free Descriptive Literature, or See It At . .

THERAPEUTIC APPLIANCES, INC.

JULES MORSTEIN

1114 Light St. Phone 752-6996

Baltimore, Md. 21230

AN EVENING WITH
VIRGIL THOMSON
and
ELAINE BONAZZI,
MEZZO-SOPRANO

TUESDAY 8:30 p.m.
OCTOBER 28, 1969

AN EVENING OF
PORTUGUESE MUSIC
with
THE PEABODY ORCHESTRA
ALVARO CASSUTO,
GUEST CONDUCTOR

TUESDAY 8:30 p.m.
NOVEMBER 11, 1969

THE PEABODY CHORUS
GREGG SMITH,
CONDUCTOR
music of
EARLE BROWN,
RESIDENT COMPOSER

FRIDAY 8:30 p.m.
JANUARY 16, 1970

PEABODY CONSERVATORY



CANDLELIGHT CONCERTS

Peabody Concert Hall
1 E. Mt. Vernon Pl.
Baltimore, Md. 21202
837-0600



BOLTON HILL *Dinner Theatre*

"The Impossible Years"
Through Sept. 21

"The Public Eye"
And
"Black Comedy"
Sept. 22 — Oct. 19

Dinner — 7 P.M.
Performance — 8:30 P.M.
FREE PARKING
CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
5 PM — 2 AM

for Reservations
call 728-0800

Baltimores Only Professional Dinner Theatre



PLANNING, ENGINEERING, INSTALLATION & SERVICE
We Feature **AMPEX**
VIDEOTAPE RECORDING EQUIPMENT
Call Today for a Free Demonstration

high fidelity house

6307 YORK ROAD (*Drumcastle*) BALTIMORE, MD.
Phone 323-3713

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA
Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

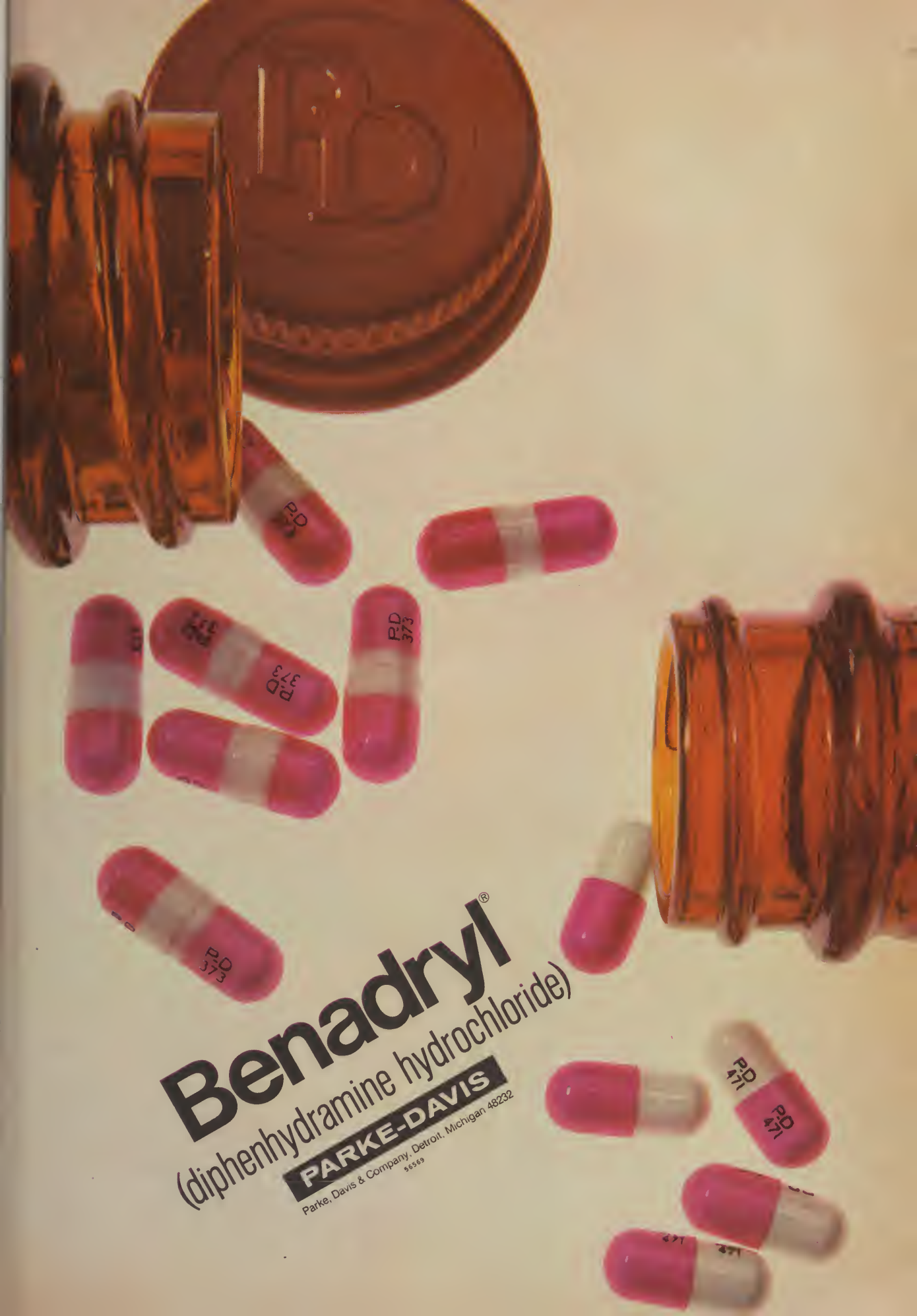
Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

CHARLES W. NEVILLE, JR., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—254-3201


Benadryl®
(diphenhydramine hydrochloride)
PARKE-DAVIS
Parke, Davis & Company, Detroit, Michigan 48232
56569

now he can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

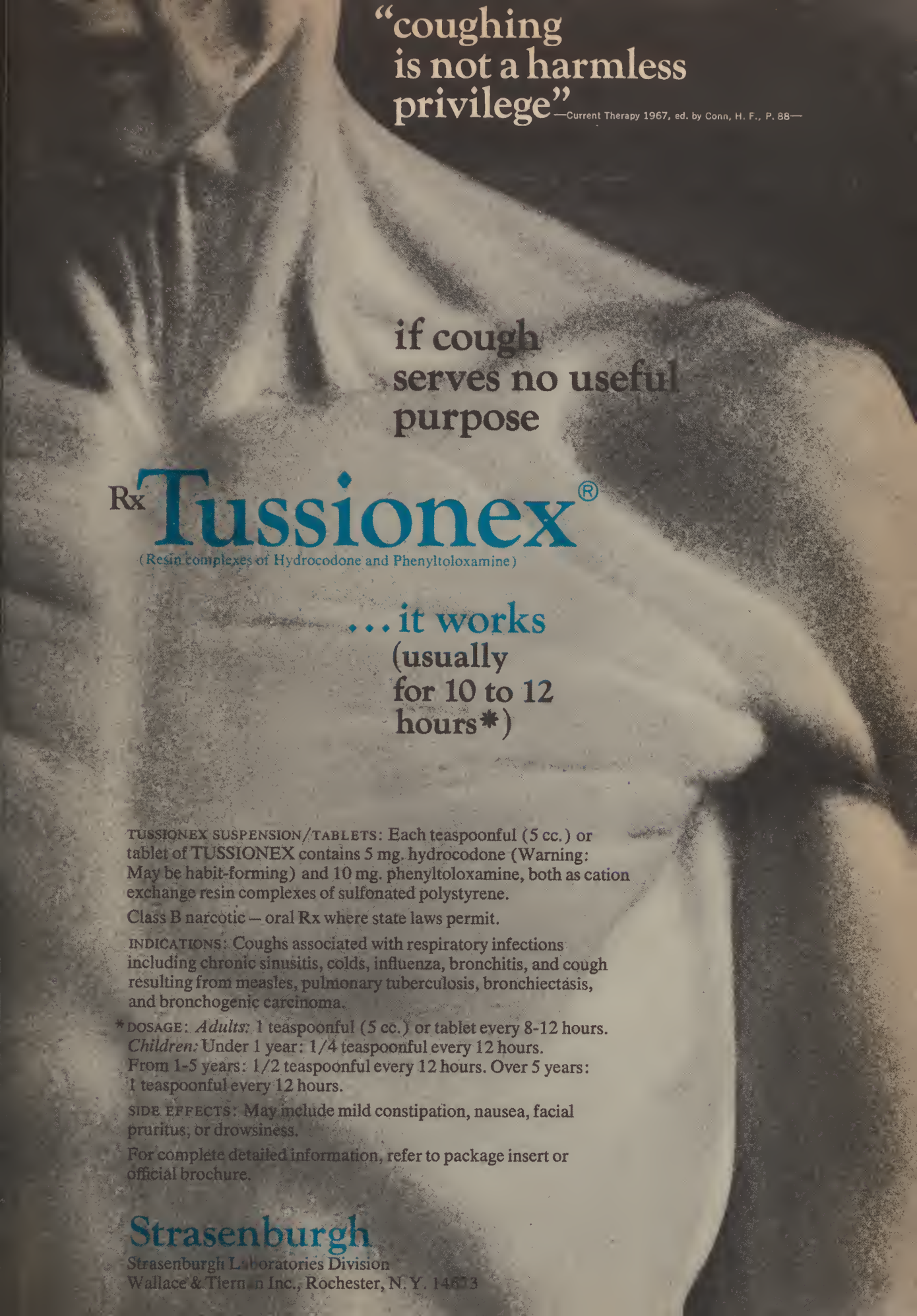
Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.





TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh

Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623



No place for beginners

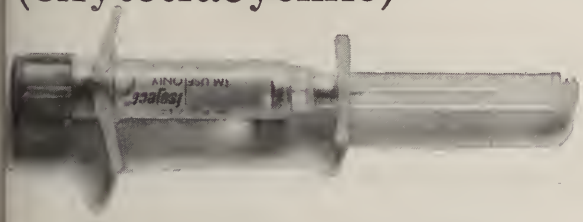
Terramycin®
(oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.

Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

THE MONTH

The American Medical Association questioned whether the Department of Health, Education and Welfare has the authority to issue its recent regulation limiting physicians' fees under medicaid.

"We question whether the authority granted by the Congress embraces the promulgation of this regulation," Ernest B. Howard, MD, executive vice president of the AMA, said in a letter to HEW.

"This regulation appears to reverse the roles of state and federal government established in the law itself."

The regulation limits most physicians' fees to the 75th percentile of the customary charge —the maximum customary fee of 75% of the physicians in the area.

After offering HEW the cooperation of the AMA in its efforts to contain rising medicaid costs, Dr. Howard pointed out that the "comprehensive" care goal of the program could not be achieved "without substantial funding, both state and federal."

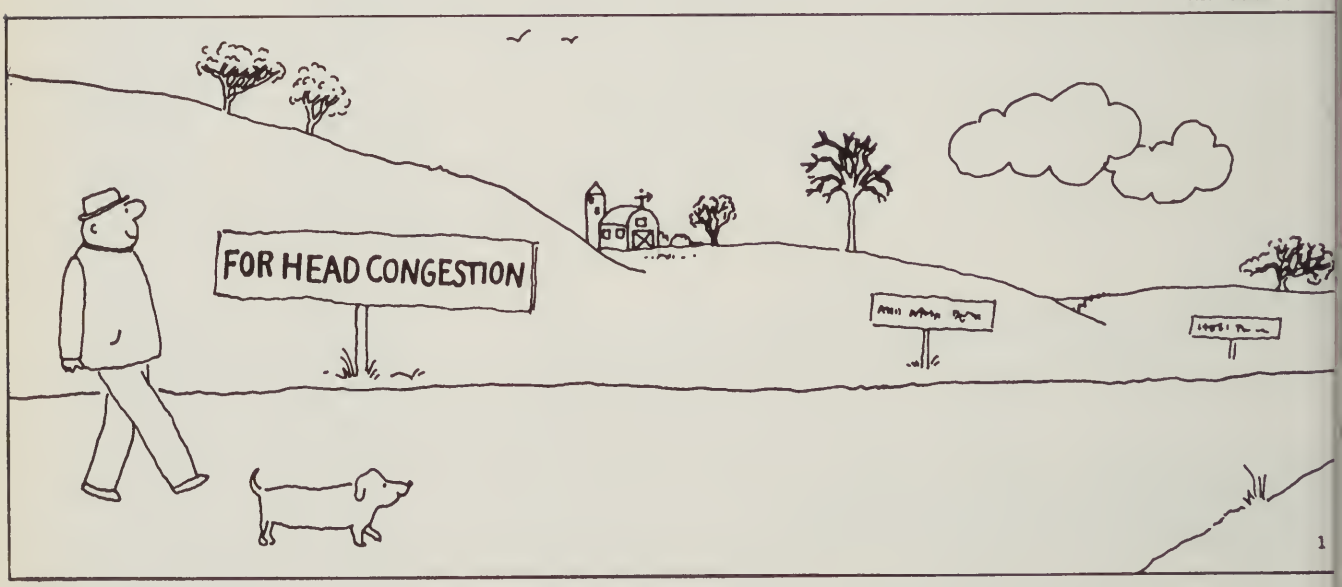
"Moreover, it has always been recognized that the intent of Title XIX (medicaid), when adopted, was to dissolve any barriers which existed between medical care available to the medically indigent and other citizens," the AMA statement said.

"It also recognized that payment to physicians participating in the government program should be on the basis of reasonable charges, ie, usual charges of the physician within the customary range of charges for similar services in the community, so as to assure a broad range of participation by physicians in the program and eliminate one of the obstacles to the care of patients on the same level as that provided other persons in the community. This was essentially the approach taken in the January 25, 1969, regulations concerning "Reasonable Charges," in which "Customary charges which are reasonable" was established as the upper limit for payment for non-institutional services. We believe that the January 25th pronouncement more accurately comports with the Congressional intent expressed in Section 1903(a)(30) of the Medicaid law, than does the new regulation. . . .

"In departing from this earlier standard, by establishing arbitrary limits on payments to individual practitioners, it should be recognized that the July 1 regulations may again raise a barrier to providing private care to the medically indigent.

"There can be no question that any fee abuses in the program, whether by individual practitioners or other providers, must be ferreted out and eliminated. On the other hand, the true effect of the proposed regulations must be kept in proper perspective, since physicians' fees represent only approximately 11% of the costs of the Medicaid program. Consequently, if the basic concern is with the total costs of the program, the remedy

Advertisement



IN WASHINGTON

in our opinion, is not through regulations which restrict physicians' charges."

On the Congressional front, the medicaid law was amended to give the states some relief in fiscal difficulties arising from the program.

States now have until July 1, 1977, to submit comprehensive plans of medical care for all needy persons under medicaid. Under the original medicaid law, participating states had to come up with such a plan by July 1, 1975. But rising health care costs resulted in medicaid fiscal difficulties for so many states that Congress delayed the deadline for two years and relaxed other requirements to ease the financial bind.

One of the new amendments permits states to reduce their services under medicaid. In the past, they couldn't. But a state still cannot reduce over-all medicaid spending.

Rep. Wilbur D. Mills (D., Ark.), chairman of the House Ways and Means Committee, said the changes in the law should give states some financial relief and also give Congress time to consider what long-range revisions are desirable in medicaid.

* * *

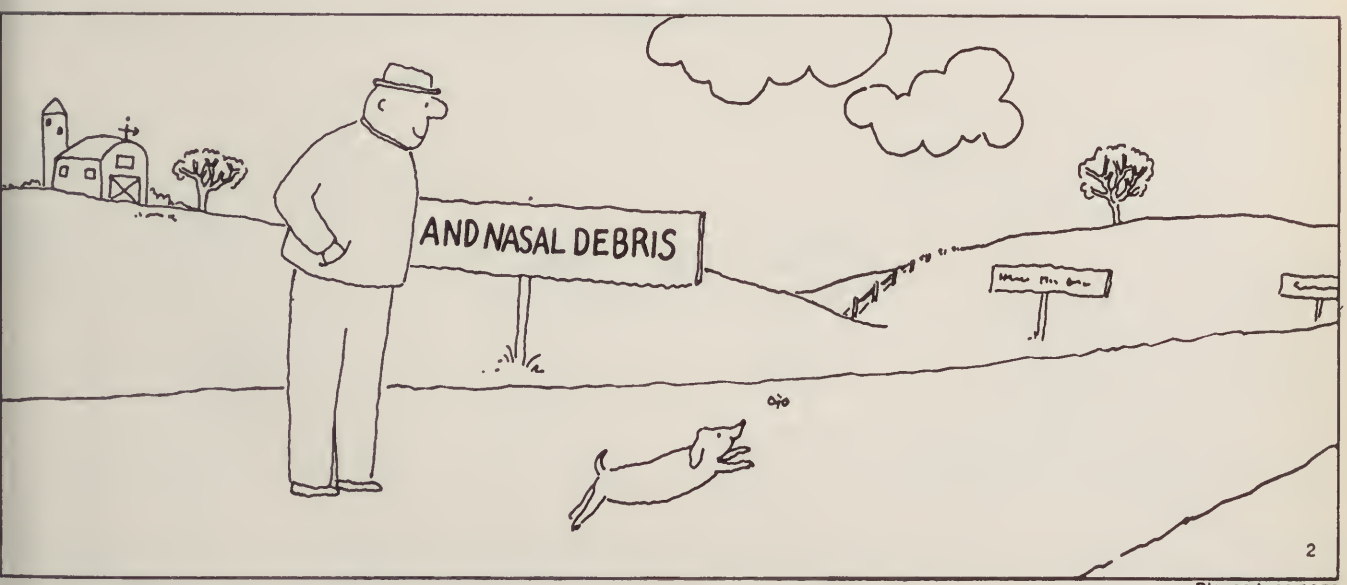
President Nixon said the nation will be confronted with a "massive" crisis in health care unless government and the private sector cooperates to hold down costs and to improve the system of delivery of medical services.

He made the statement in commenting on Health, Education and Welfare Department's "Report on the Health of the Nation's Health Care System." It carried the names of both HEW Secretary Robert H. Finch and HEW Assistant Secretary for Health and Scientific Affairs Roger O. Egeberg, MD.

"This nation is faced with a breakdown in the delivery of health care, unless immediate concerted action is taken by government and the private sector," the report said. "Expansion of private and public financing for health services has created a demand for services far in excess of the capacity of our health system to respond. The result is a crippling inflation in medical costs causing vast increases in government health expenditures for little return, raising private health insurance premiums and reducing the purchasing power of the health dollar of our citizens."

The report said the medicaid program—"badly conceived and badly organized"—was a major factor in rapidly rising health care costs by attempting "to provide medical services for the poor by pushing them into the nation's already overburdened health care system without developing the capacity in the system to serve them and without building the capability in the states to manage the program."

The report also said overtaxed health resources are being used wastefully and not being expanded rapidly enough. And not



Please turn page

enough attention is being given to preventive health care, the report said.

Two advisory groups were set up: a HEW Secretary's Task Force on Medicaid and Related Programs under co-chairmen HEW Undersecretary John G. Veneman and Walter J. McNerney, president of Blue Cross, and a special industry group with David J. Mahoney, president of Norton Simon, Inc., as chairman.

Dwight L. Wilbur, MD, then president of the American Medical Association, congratulated the Nixon Administration for taking "such a thoughtful look at the accumulated problem that has been built up in the past as a result of hurriedly enacted programs, the buildup of unattainable expectations and creation of unsound administrative operations."

"Correcting the consequences of massive disruptions and past political errors will call for the cooperation and dedication in the government and private sectors," Dr. Wilbur said. "This includes physicians, other professionals, many in related fields, hospitals, government, insurance payors and many others."

Dr. Wilbur also welcomed a call by Finch and Dr. Egeberg for discipline through the profession itself of "the very few members of the medical profession who have reportedly abused the (medicare and medicaid) programs."

* * *

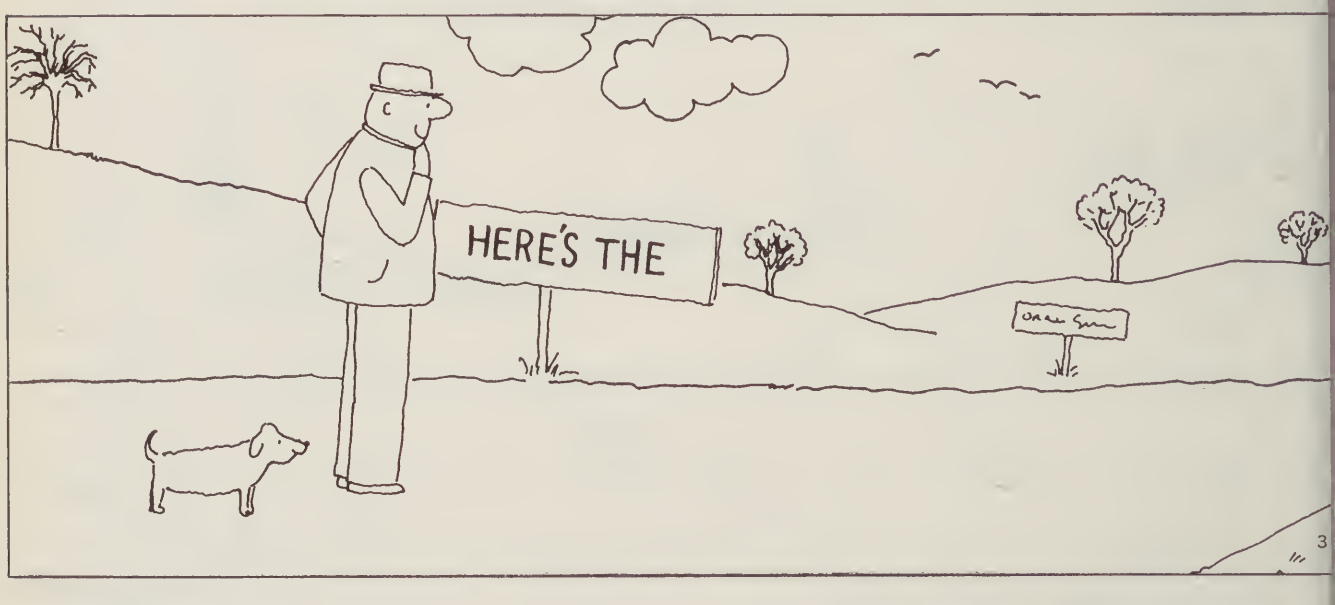
Recent testimony by AMA witnesses before Congressional committees included **Dr. O. L. Simenstad,** member of the AMA Board of Trustees, before the Senate Monopoly (Nelson) Subcommittee:

"The advertising policies of the AMA have recognized consistently the uniqueness of drug advertising in that it should not be directed to the public, but to physicians, and because of the public interests involved, it should be responsibly presented. As the drug products in this country have become more sophisticated, the Association's advertising policies have undergone evolution. Initially, an 'ethical' manufacturer was required to disclose the formula of his advertised products. 'Secret nostrums' could not be advertised in responsible medical journals such as JAMA. Today, honest presentation of claims is the primary criterion. . . .

"The policy of the AMA has been to update the advertising standards as the drug field changes. Two of the basic tenets have remained unchanged, however. One is that 'the appearance of advertising in AMA publications is not an AMA guarantee or endorsement of the product or the claims made for the product by the manufacturer, and the other is that advertising space will not be sold unless 'the inclusion of advertising material does not interfere with the purpose of the publication.' "

—Dr. Pierre Salmon, member of the AMA Committee on Aging, before the Senate Long-Term Care Subcommittee:

"We believe that the medical profession should take the lead in organizing 'community coordinating committees' to assume over-all responsibility in coordinating available health facility services in the community. We have suggested that local medical societies invite representatives of the other health agencies and professions in the area to discuss and consider jointly the community's particular problems with regard to long-term care—both convales-



cent and custodial care. Some local medical societies have taken this initiative."

—Dr. Frederick C. Swartz, chairman of the AMA Committee on Aging, before the Senate Subcommittee on Health of the Elderly:

"Age is no bar to good medical or surgical treatment including open heart surgery, so long as the patient presents himself as a reasonably physiologically functioning unit to the physician.

"The medical and paramedical services—the physician and the para-physician personnel—must begin to realize that something can be done for diseases found among the oldsters. The days of condescension medicine to 'grandpap' and 'grandma' is at an end."

—Philip L. White, secretary of the AMA Council on Foods and Nutrition, before the Senate Committee on Nutrition and Human Needs:

". . . the United States needs to develop a national nutrition policy. . . . The development of goals in food production and distribution, the establishment of adequate levels of nutrient intake for individuals and groups of people, plans for the nourishment of our future expanded populations are but a few of the issues which require national attention."

—Dr. Henry Brill, chairman of the AMA Committee on Alcoholism and Drug Dependence, before the House Education Subcommittee:

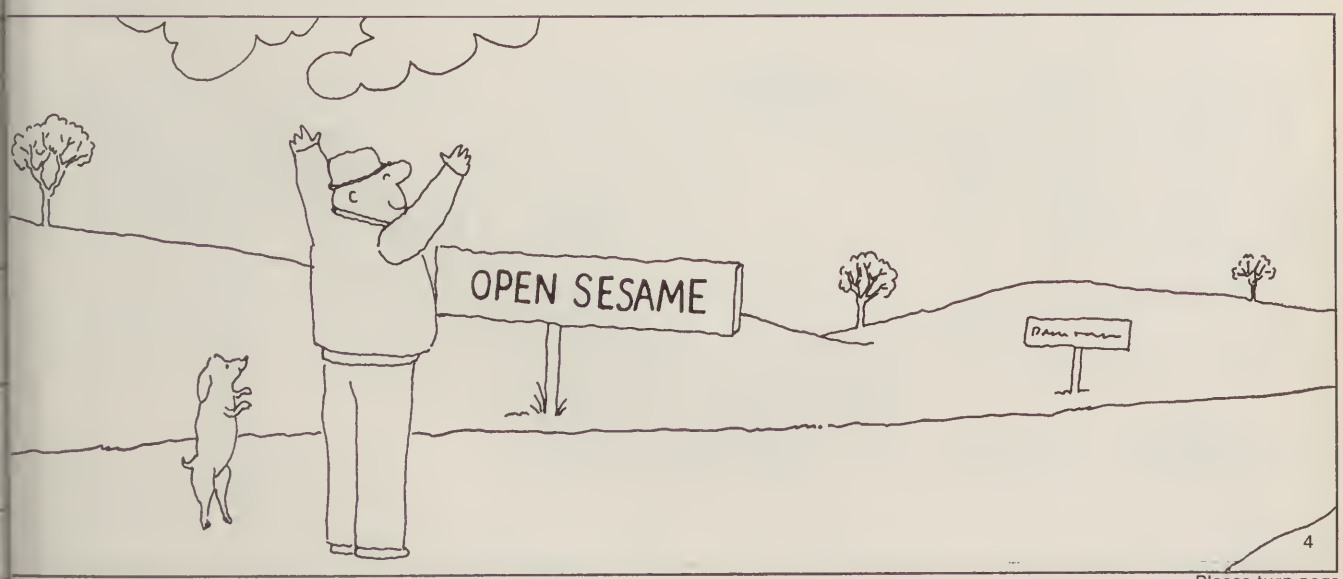
"In the course of the AMA's work in this field, we have been profoundly impressed by the fundamental importance of public education about narcotic, depressant and stimulant drugs. In the first instance, of course, public information has a decisive impact on public attitudes and opinions, and in the long run this determines public policy. If drug taking for pleasure should ever become socially acceptable in this country and accepted as a harmless pastime, one could confidently predict that control of drug dependence would become impossible."

—Dr. Marvin A. Block, a member of the AMA Committee on Alcohol and Drug Dependence, before the Senate Subcommittee on Alcoholism and Narcotics:

". . . the crying need, aside from that of research and education, is for community facilities to treat and care for the alcoholic patient, who is entitled to the same rights and opportunities for treatment accorded other sick people."

Did You Know?

- Loans for hospitals and medical construction in blighted urban areas, under a special billion-dollar investment program of the life insurance business, is just under $100 million.
- The money available to build medical facilities in urban areas created permanent jobs for 13,000 persons during the program's first 14 months.
- The largest single portion of these health facilities loans went for hospital construction—nearly $67 million.



Please turn page

Mental Health Of Urban America

Reviewed In New Report

The paradox of the cities as one of civilization's crowning achievements and most challenging scourges —and what is being done to solve urban mental health problems—are examined in a new report by the National Institute of Mental Health.

"The Mental Health of Urban America—The Urban Programs of the National Institute of Mental Health" is the just published 140-page report.

Giving emphasis to how research, training, and service activities interact in the search for solutions to urban mental health problems, the report cites 240 specific urban projects conducted or supported by the Institute.

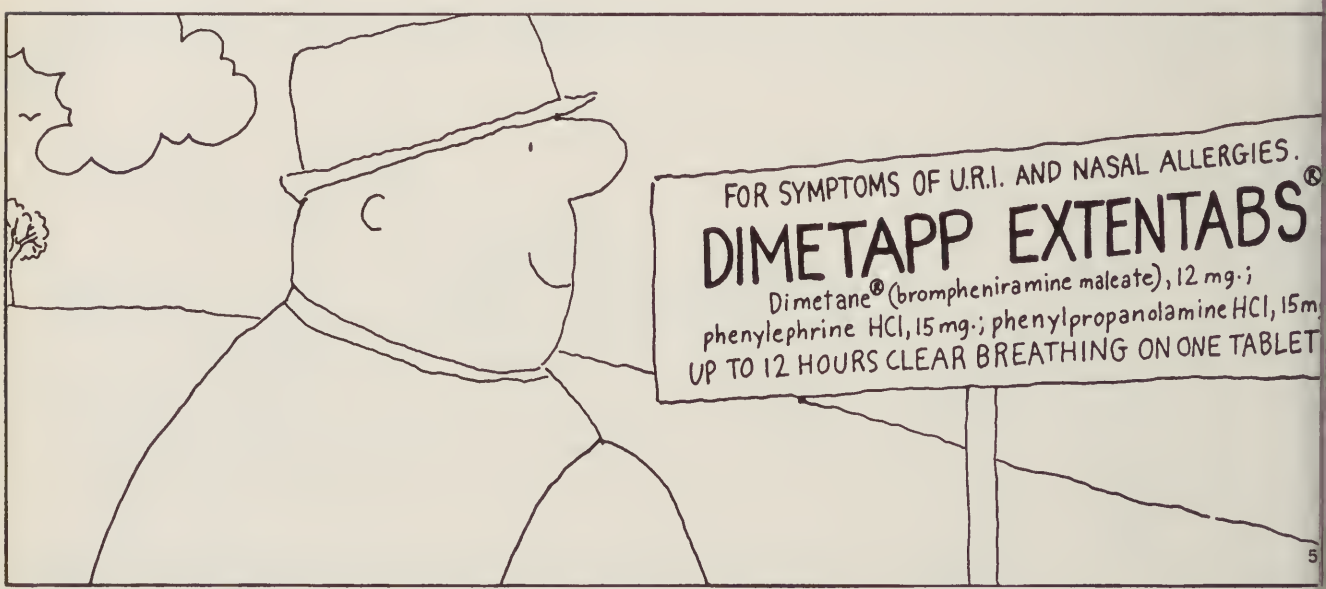
Seven out of every ten Americans—or 140 million—live in cities today, the report says, but by 2000 this figure will rise to 80% of the population—or 285 million. Coupled with this rising trend in the urban population is an already disproportionately high urban incidence of mental illness, crime, delinquency, drug abuse, violence, illegitimacy, suicide, alcoholism, and other social problems.

How these special mental health problems of the cities are being tackled is described in the report, covering projects in such areas as riot prevention, prevention and treatment of delinquency, and drugs as an urban problem.

Bringing mental health services to the urban community is the aim of many Institute programs, according to the report. These include activities for the development of community centers, demonstrations in helping slum residents, and neighborhood service programs.

Manpower needs and training to develop various kinds of personnel to combat urban mental health problems are outlined in the report. Descriptions of projects to train entirely new kinds of professional, as well as allied workers emphasize the innovative aspects of manpower development, while programs are also cited for increasing the pool of psychiatrists, psychologists, psychiatric nurses, and mental health social workers.

Single copies of "The Mental Health of Urban America," (PHS Publication No. 1906) are available free from the National Institute of Mental Health. Additional copies are for sale at $1 each by the Superintendent of Documents, U. S. Government Printing Office, Washington, D. C. 20402.



Baltimore Association of Medical Assistants

The Womanly Art of Self-Defense

At the monthly meeting of the Baltimore Association of Medical Assistants, held on Tuesday, April 8, at the Deutches Haus, Policewoman Mercedes Rankin of the Community Relations Division, Baltimore City Police Department, was guest speaker.

Her topic, "The Womanly Art of Self-Defense," was illustrated with a film depicting a common assault and robbery of an unprotected woman, and methods of defense against such an attack. Following the film, Policewoman Rankin discussed numerous precautionary and retaliatory methods of protection.

Laboratory Orientation Course

The Baltimore Association of Medical Assistants recently offered a couse in laboratory orientation. Conducted at Drs. Wollenweber and Wright's office and laboratory, 1114 Cathedral Street, the course was held for eight consecutive weeks beginning April 18, 1969, in conjunction with the AAMA certification program. The material covered included: Urinalysis, Hematology, Bacteriology, Immunology, Injections, EKG, Radiology, and Physiotherapy.

Instructors for the course were: Robert H. Wright, MD; Mr. John Komber, ASCP, MT; Mr. Joseph Casino, and Mr. Louis L'Archeveque, MT, ASCP, CSLT.



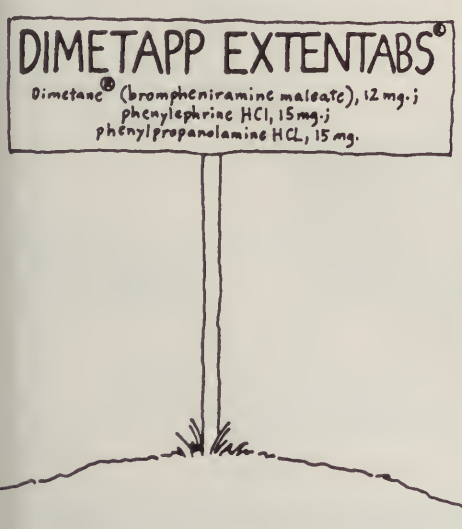
Mr. L'Archeveque

Annual Bosses' Night

On May 13, 1969, BAMA held its Annual Bosses' Night at the Eastwind Restaurant. The evening was a purely social event.

Following cocktails and dinner, members of the association entertained the guests for the evening with a presentation entitled "Laugh-Out—Smash-In." Members of the cast included John Allen, Peggy Bury, Barbara Daniel, Elva Edmonston, Donna Fedeli, Mary Margaret Frederick, Dorothy Hartel, Bill Leiby, Carmella Sartori, and Catherine Taylor.

(Continued next page)



INDICATIONS: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, hayfever and conjunctivitis.

CONTRAINDICATIONS: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.

PRECAUTIONS: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.

SIDE EFFECTS: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.

DOSAGE: 1 Extentab morning and evening.

SUPPLIED: Bottles of 100 and 500.

A·H·ROBINS A. H. ROBINS COMPANY RICHMOND, VIRGINIA 23220

6

Arrangements for the enjoyable evening were made by Rita Cobry and Dolly Struck. Mrs. Struck and Mrs. Cobry made favors which were presented to each physician in attendance.

Ronald N. Kornblum, MD Guest Speaker in June

At the monthly meeting of the Baltimore Association of Medical Assistants, Ronald N. Kornblum, MD, spoke on "The Green Revolution," which dealt with the problem of drug addiction. During his talk, Dr. Kornblum showed slides of typical "mainliner" methods of heroin addiction and also post-mortem findings in addicts who had taken an overdose of drugs.

He explained many of the hazards of marijuana as well as LSD, and he pointed out that young people seem to be in the majority in drug abuse. Dr. Kornblum's talk was most educational and gave his audience a stark realization of the sadness of drug addiction.

Dr. Ronald N. Kornblum, was born in Chicago, Illinois. He attended the University of California and was graduated in 1955 with a major in Zoology. He then attended the University of California School of Medicine and served his internship at the Great Lakes Naval Hospital. He was General Medical Officer in the U.S. Navy from 1960 to 1962. He served his Pathology residence at Santa Clara County Hospital in California. From 1966 to 1967, he was a resident in Neuropathology at the Central Anatomic Laboratory, and is now in Forensic Pathology at the Medical Examiners Office in Baltimore.



Dr. Kornblum

★ This extended care Nursing Home is Approved by the Joint Commission on Accreditation of Hospitals

★ One story new fire-safe construction.

★ No steps, ramps or elevators needed.

★ Inspection invited. Reasonable rates.

★ All facilities available to private physicians.

Where your convalescent Elderly, Bedfast or Disabled

Enjoy being special

V. I. P.'s

(VERY IMPORTANT PARENTS)



★ Professional Total Care Program.

★ Continuous Physical Rehabilitation by registered therapists in specially equipped department.

PHONE VALLEY 8-6500

Dulaney Towson

NURSING & CONVALESCENT HOME

111 West Road, Towson

Off York Rd. Beltway Exit 26 South



vacation in a vial: the spasm reactors in your practice deserve

"the Donnatal® Effect"

	each tablet, capsule or 5 cc. of elixir (23% alcohol)	each Donnatal No. 2	each Extentab®
hyoscyamine sulfate	0.1037 mg.	0.1037 mg.	0.3111 mg.
atropine sulfate	0.0194 mg.	0.0194 mg.	0.0582 mg.
hyoscine hydrobromide	0.0065 mg.	0.0065 mg.	0.0195 mg.
phenobarbital	(¼ gr.) 16.2 mg.	(½ gr.) 32.4 mg.	(¾ gr.) 48.6 mg.
(Warning: may be habit forming)			

Brief Summary. Blurring of vision, dry mouth, difficult urination, and flushing or dryness of the skin may occur on higher dosage levels, rarely on usual dosage. Administer with caution to patients with incipient glaucoma or urinary bladder neck obstruction. Contraindicated in acute glaucoma, advanced renal or hepatic disease or a hypersensitivity to any of the ingredients.

A. H. ROBINS COMPANY, RICHMOND, VIRGINIA 23220

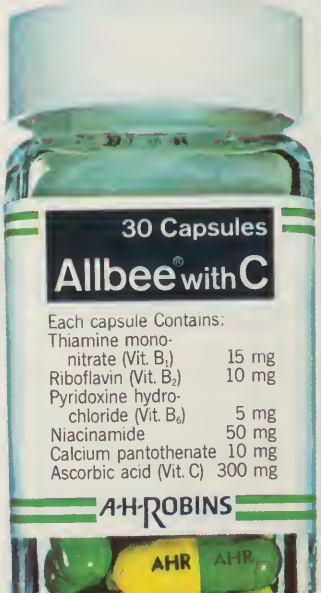
A·H·ROBINS

Two ways to provide your patients with a month's therapeutic supply of Vitamin C:



290 tangerines or 30 Allbee® with C.

Your patient would have to peel and eat 290 tangerines a month, almost 10 every day, to get as much Vitamin C as is contained in just one bottle of 30 Allbee with C capsules (taken one capsule daily). In addition, each capsule provides full therapeutic amounts of the B-complex vitamins. For example, as much niacin as 2 pounds of sirloin steak. This handy bottle of 30 Allbee with C capsules gives your patient a month's supply at a very reasonable cost. Also the economy size of 100. Available at pharmacies on your prescription or recommendation.



A.H. Robins Company, Richmond, Va. 23220

Baltimore's Gourmet mail order seafood house offers shipments of fresh Chesapeake Bay Seafood . . .

anywhere in the country



. . . to the home, with customer satisfaction guaranteed. Shipments arrive in perfect condition or we reship at our expense or refund.

Chesapeake Farm Inc.

110 NORTH EUTAW STREET
BALTIMORE, MARYLAND 21201

Phone 685-8882
685-4685

Symbols in a life of psychic tension

M.A.

class of '66

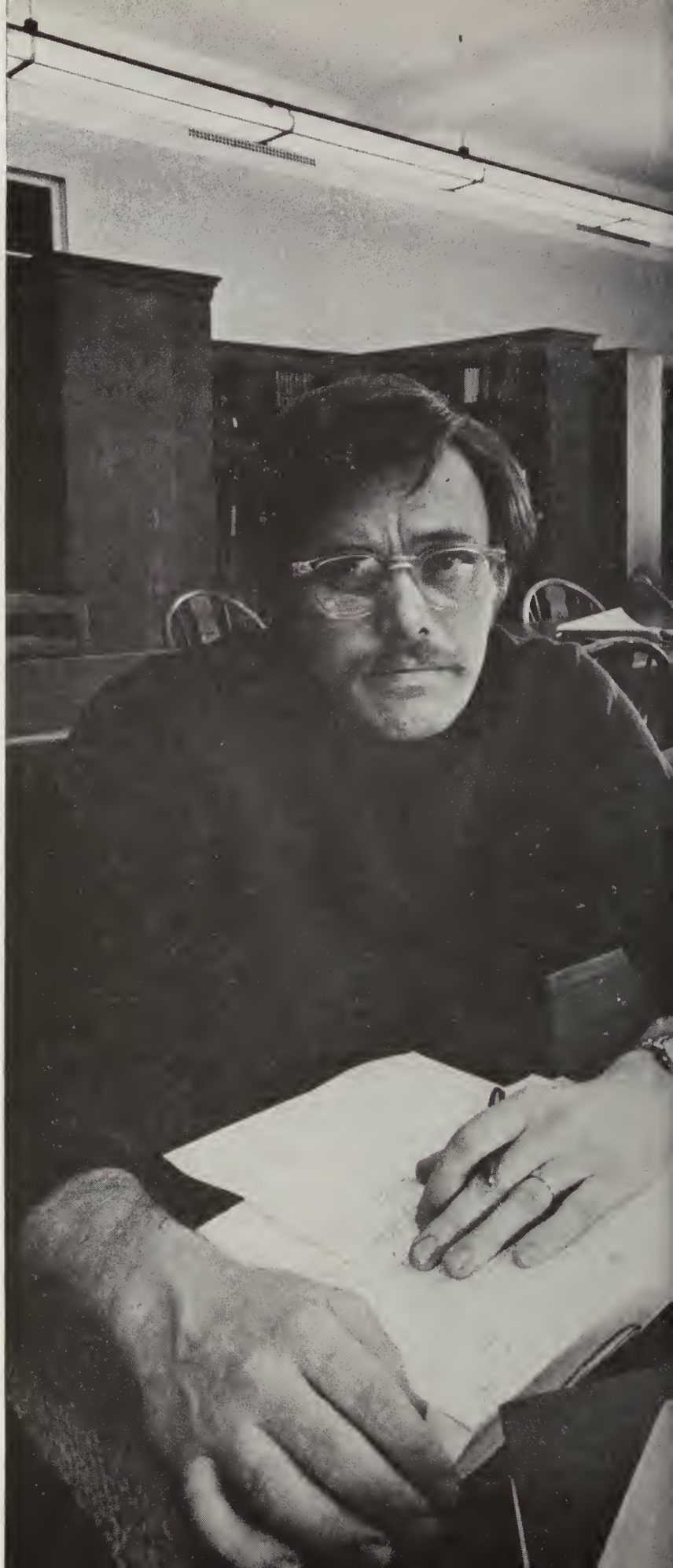
Ph.D.

thesis...in progress

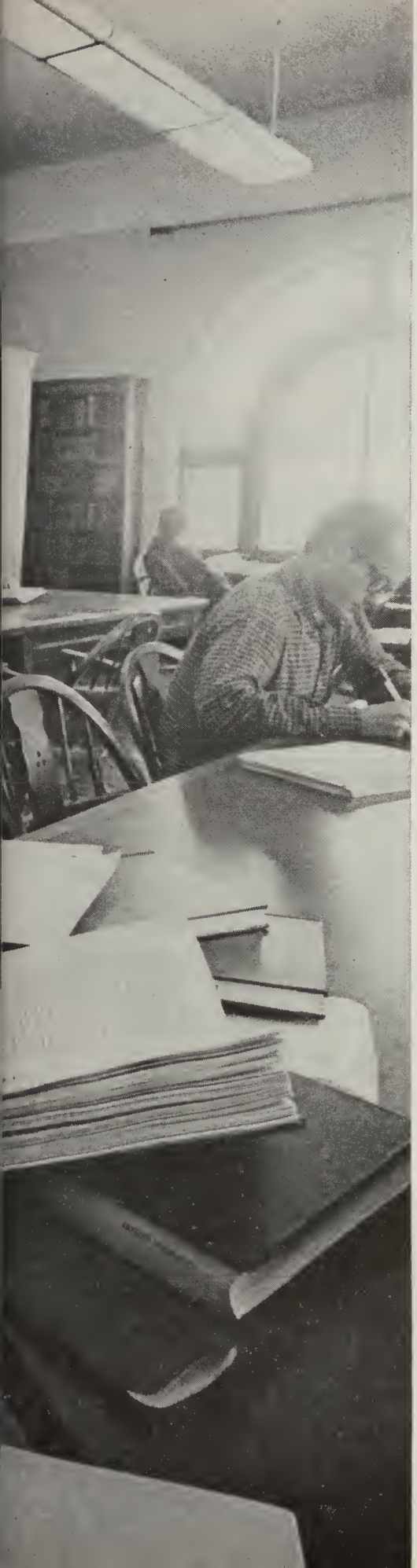
G.I.

series and complete examination normal

(persistent indigestion)



ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



Rx

Valium® (diazepam) *t.i.d.* and *h.s.*

M. A. (class of '66)... Ph.D. (thesis, in progress)... letters that represent a young lifetime of work... a formal education nearing completion. But there are still long, arduous examinations to pass, a doctoral thesis to finish... a period in which stress is often converted into the gastrointestinal symptoms of psychic tension. For this kind of patient—with no demonstrable pathology—consider the usefulness of Valium (diazepam).

Valium can help relieve psychic tension and resultant somatic symptoms, within the first day for some patients. Valium is also useful in psychic tension with associated depressive symptoms. And Valium can help relieve psychic tension-induced insomnia with an *h.s.* dose added to the *t.i.d.* schedule.

Valium is generally well tolerated. In proper maintenance dosage it seldom dulls the senses or interferes with functioning. Side effects most commonly reported have been drowsiness, fatigue and ataxia.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Valium® (diazepam)

2-mg, 5-mg, 10-mg tablets
to help relieve psychic tension
and its somatic symptoms

"I'm sick of spinning"



When vertigo began, her life took a turn for the worse.
Either she spins and the room stands still,
or the other way around... and around and around.
Even when she lies down, the spinning
continues. Sometimes there's nausea and vomiting, too.
It's just one thing after another.

You can help stop the spin with

BONINE®

(MECLIZINE HCl)

Bonine protects most patients against vertigo and nausea up to 24 hours with a single dose. Pleasant-tasting Bonine tablets are chewable and can be taken anytime, anywhere, without water. In difficult cases, multiple daily doses may be necessary for maximum response.

Precautions: Although the incidence of drowsiness and atropine-like side effects such as dry mouth and blurring of vision is low, the physician should alert the patient to the need for due precautions when engaging in activities where alertness is mandatory. *Use in women of childbearing age:* In weighing potential benefits vs. risk in women of childbearing age, consider the fact that a review of available animal data reveals that meclizine exerts a teratogenic response in the rat. In one study a dose of 50 mg./kg./day (50 times the maximum recommended human dose) produced cleft palate in 2 of 87 fetuses when administered to the rat at critical times during the first 15 days of gestation. At doses of 125 mg./kg./day, meclizine will produce 100% incidence of cleft palate in the rat. At doses of 25 mg./kg./day, decreased calcification of the vertebrae and relative shortening of the limbs were also produced in the rat, but experts disagree as to whether this is a teratogenic response. While available clinical data are inconclusive, scientific experts are of the opinion that this drug may possess a potential for adverse effects on the human fetus. Consequently, consideration should be given to initial use of a nonphenothiazine agent that is not suspected of having a teratogenic potential. In any case, the dosage and duration of treatment should be kept to a minimum.
Supply: 25 mg. scored tablets.
More detailed professional information available on request.

Pfizer
LABORATORIES DIVISION
New York, N.Y. 10017



IN BALTIMORE.....

House In The Pines Nursing Homes have the facilities and experience to care for those you care for

HOUSE IN THE PINES
NURSING HOMES

PROFESSIONAL CARE FOR THE AGED, CHRONICALLY ILL AND CONVALESCENT.

• Bright, pleasant surroundings and a home-like atmosphere • Fire-safe accommodations • Competent professional care, 24 hours a day • Complete Physical and Occupational Therapy facilities and programs under the direction of our licensed staff therapists

• Modern kitchens supervised by licensed staff dietitian provide tasty, balanced meals.

BEL AIRE — 5837 Belair Road — CL 4-8800
BELVEDERE — 2525 W. Belvedere Ave. — FO 7-9100
CATONSVILLE — 16 Fusting Ave. — RI 7-1800
also Easton, Md., Rt. 50 & Dutchman's Lane. TA 2-4000

YOUR INSPECTION INVITED • BROCHURE ON REQUEST

SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

APRIL 1, 2, 3, 1970

The Alcazar, Baltimore

As space is limited, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

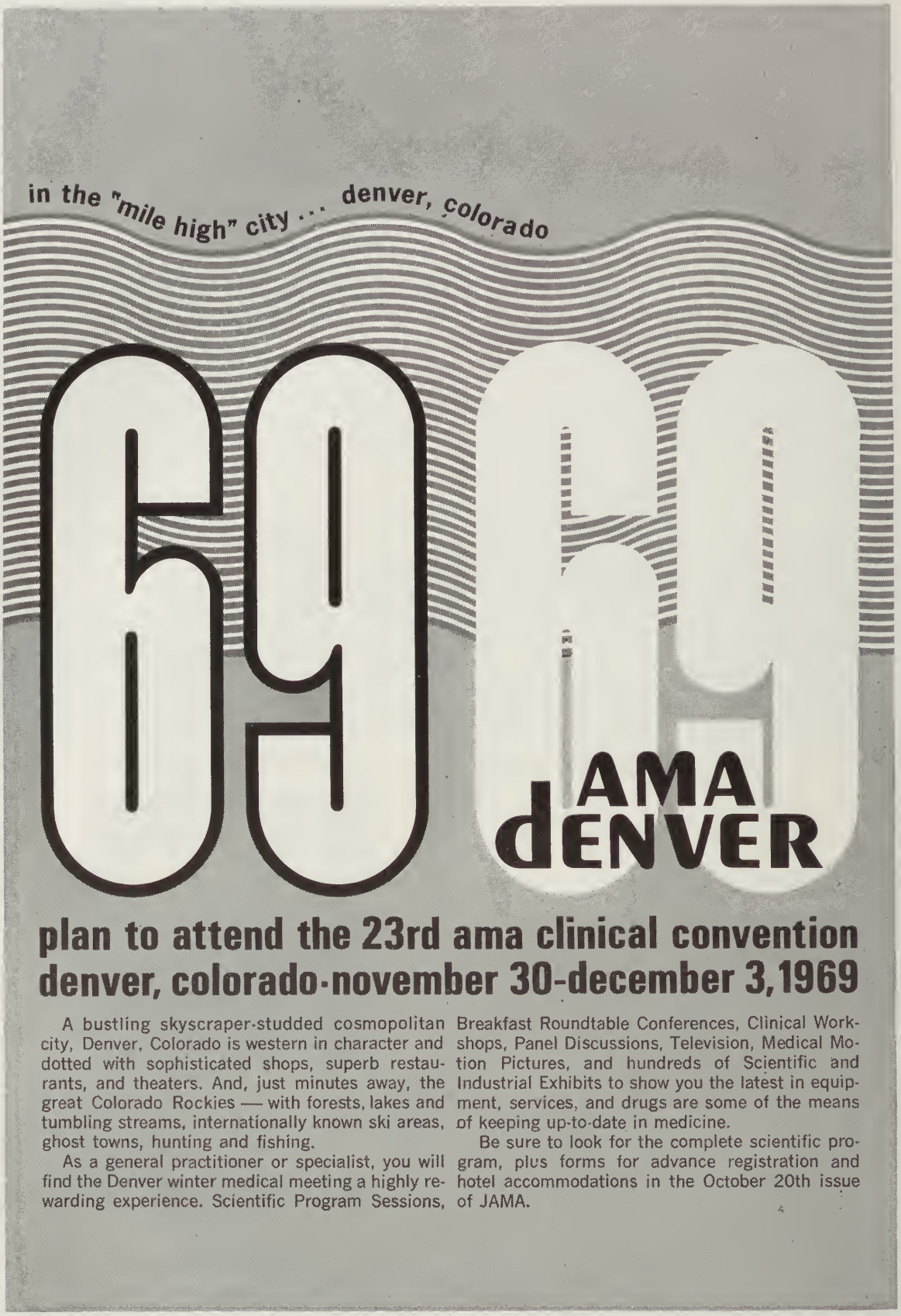
7. Name of institution cooperating in the exhibit: _____

_____

8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS



plan to attend the 23rd ama clinical convention denver, colorado-november 30-december 3,1969

A bustling skyscraper-studded cosmopolitan city, Denver, Colorado is western in character and dotted with sophisticated shops, superb restaurants, and theaters. And, just minutes away, the great Colorado Rockies — with forests, lakes and tumbling streams, internationally known ski areas, ghost towns, hunting and fishing.

As a general practitioner or specialist, you will find the Denver winter medical meeting a highly rewarding experience. Scientific Program Sessions, Breakfast Roundtable Conferences, Clinical Workshops, Panel Discussions, Television, Medical Motion Pictures, and hundreds of Scientific and Industrial Exhibits to show you the latest in equipment, services, and drugs are some of the means of keeping up-to-date in medicine.

Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 20th issue of JAMA.

LIST OF INTERPRETERS

The following list of interpreters was compiled by the Woman's Auxiliary of the Medical and Chirurgical Faculty with the help of the Baltimore Council of International Visitors. Classified by language, the list includes the names of physicians who are either foreign born or have acquired fluency in a foreign language, as well as the names of the volunteers to this program.

The purpose of this list is to serve foreign-speaking visitors who seek medical advice from physicians who are not conversant in the visitor's language.

GENERAL CONTACTS

Automobile Association of America "Language Bank"
Confidential list for telephone emergency service
Open 24 hours a day—Telephone 685-4000

District of Columbia Embassies

Consulates in Baltimore, etc.

Y.W.C.A. International Center
Mrs. Lena Roth—Telephone PE 2-7032
Home Phone HA 6-8270

Baltimore Council of International Visitors
305 N. Charles Street, Baltimore
Telephone: 727-1749
(Mrs. Matthew Hirsh, President)

International House—Hopkins School of Medicine
Telephone—955-3934

Gallaudet College, Washington, D.C. (for deaf-mutes)

LANGUAGES

Algerian
Miss Clemence Genah (no car)
3303 W. Northern Parkway
Baltimore, Md. 21215—Telephone: 358-9422

Albanian
Mrs. Ulysses Milli
Silver Spring, Md.—Telephone: 593-9296

Arabic
Mrs. Amina Ramiz
8506 Glen Michael Lane, Randallstown, Md.
Telephone: 922-8225

Mrs. Lily Haresh
6837 Fieldcrest Road, Baltimore 21215
Telephone: 358-4126

Austrian ("High German")
Mrs. Elizabeth Bix
6815 Timberlane Rd., Baltimore 21209
Telephone: HU 4-1664

Mrs. Laszlo Steingaszner
805 Stags Head Road, Towson 21204
Telephone: 825-1736

Bengati (India)
Dr. Tapan Hazra
5104 Lodestone Way, Baltimore
Telephone: 488-3507

Cebuano (Philippines)
Mr. Steve Warres
3314 Fallstaff Road, Baltimore 21215
Telephone: 358-1151

Chinese
Mrs. Morton Abramowitz (Mandarin dialect)
4705 Fallstone Road, Chevy Chase 20015
Telephone: 656-5876

Mr. William Chu (Mandarin dialect)
109 Enchanted Hills Road, Owings Mills
Telephone: 356-4892

Czech
Mrs. Eugene Schnitzer
3307 Terrapin Road, Pikesville 21208
Telephone: 486-4080

Mrs. Eliska Novotny
909 Hilltop Avenue, Abington 21009
Telephone: 676-2316

Danish
Danish Seamen's Church of Baltimore
26 South Broadway
Telephone: 342-1717

Reverend Asbjarn Nilsen
4313 Walther Avenue
Baltimore, Maryland
Telephone: 254-7027 or Br. 6-8510

Mr. Oddvar Nielsen
639 Piccadilly Road
Towson, Maryland 21204
Telephone: 823-4998

Dutch

Mrs. Lincoln Newfield
827 Lake Drive, Apt. K2, Baltimore 21217
Telephone: 523-4422

Egyptian

Miss Lily Horesh
6937 Fieldcrest Road, Baltimore 21215
Telephone: 358-4126

Mrs. Amina Ramiz
8506 Glen Michael Lane, Randallstown 21133
Telephone: 922-8225

French

Miss Clemence Genah (no car)
3303 W. Northern Pkwy., Baltimore 21215
Telephone: 358-9422

Mrs. Andre von Fesus
1902 A Indian Head Road, Baltimore 21204
Telephone: VA 5-8311

Mrs. Ataola Golpira
1104 Gypsy Lane West, Towson 21204
Telephone: 823-3119

Mrs. Lazlo Steingaszner
805 Stags Head Road, Towson 21204
Telephone: 825-1736

Mrs. Charles Spicknall
Jug Bridge Hill, Route 6, Frederick 21701

Mrs. Ulysses Milli
Silver Spring
Telephone: 598-9296

German

Mrs. Samuel Iwry
2401 Brambleton Road, Baltimore 21209
Telephone: MO 4-1153

Mrs. Lazlo Steingaszner
805 Stags Head Road, Towson 21204
Telephone: 825-1736

Mrs. Andre von Fesus
1902 A Indian Head Road, Baltimore 21204
Telephone: VA 5-8311

Mrs. Lincoln Newfield
827 Lake Drive, Apt. K2, Baltimore 21217
Telephone: 523-4422

Mrs. Ataola Golpira (some)
1104 Gypsy Lane West, Towson 21204
Telephone: 823-3119

Miss Betty Adler (wheelchair case)
Marlborough Apts., Baltimore 21217
Telephone: 669-1892

Mrs. Eliska Novotny (some)
909 Hilltop Avenue, Abington 21009
Telephone: 676-2316

Mrs. Charles Spicknall (some)
Jug Bridge Hill, Route 6, Frederick 21701

Greek

Mrs. Ulysses Milli
Silver Spring
Telephone: 598-9296

Gujerati (India)

Dr. & Mrs. Tapan Hazra
5104 Lodestone Way, Baltimore
Telephone: 488-3507

Hebrew

Mrs. Samuel Iwry
2401 Brambleton Road, Baltimore 21209
Telephone: 664-1153

Hindi (India)

Dr. Roma Chandra
1007 Ruppert Road, Silver Spring
Telephone: 593-5208

Dr. & Mrs. Tapan Hazra
5104 Lodestone Way, Baltimore
Telephone: 488-3507

Dr. & Mrs. P. R. Nair
3204 Parkington Avenue, Baltimore
Telephone: 764-0342

Hungarian

Mrs. Andre von Fesus
1902 A Indian Head Road, Baltimore 21204
Telephone: VA 5-8311

Dr. Henry Summers
300 Church Street, Baltimore 21225
Telephone: ST 9-2240

Mrs. Eugene Schnitzer
3307 Terragon Road, Pikesville 21208
Telephone: 486-4080

Iranian

Mrs. Ataola Golpira
1103 Gypsy Lane West, Towson 21204
Telephone: 823-3119

Italian

Dr. Andre von Fesus
1902 A Indian Head Road, Baltimore 21204
Telephone: VA 5-8311

Mr. Marius Vogelfanger
3659 Forest Garden Ave, Baltimore 21207
Telephone: 944-8559

Japanese

Dr. Ryun Ho Kim
662 Faircastle Avenue, Severna Park 21146
(Via telephone, emergency only) 987-0220

Many Japanese students at Peabody Conservatory, Baltimore

Korean

Mrs. Lucy Kim
662 Faricastle Avenue, Severna Park 21146
Telephone: 987-0220

Lebanese

Mrs. George Malouf
6809 40th Avenue, Hyattsville 20782
Telephone: 277-5885

Lithuanian

Mrs. Justinas Kudirka
40 N. Rolling Road, Baltimore 21228
Telephone: RI 7-0240

Malayalan (India)

Dr. George Ramapuram
3207 Keyser Road, Baltimore 21208
Telephone: 484-4735

Dr. & Mrs. P. P. Nair
3204 Parkington Avenue, Baltimore
Telephone 764-0342

Marathi (India)

Dr. & Mrs. Tapan Hazra
5104 Lodestone Way, Baltimore
Telephone: 488-3507

Moroccan

Miss Clemence Genah (no car)
3303 W. Northern Pkwy, Baltimore 21215
Telephone: 358-9422

Norwegian

Norwegian Consulate-General, Keyser Building
Baltimore, Maryland
Telephone: 752-1987

Mr. Oddvar Nielsen
639 Piccadilly Road, Towson 21204
Telephone: 823-4998

Norwegian Seaman's Church
300 S. Patterson Park Avenue, Baltimore
Telephone: 276-8510

Reverend Asbjorn Nilsen
4313 Walther Avenue, Baltimore
Telephone: 254-7027

Polish

Mrs. Samuel Iwry
2401 Brambleton Road, Baltimore 21209
Telephone: MO 4-1153

Portuguese

Mrs. Stanley Klatsky
8510 Stevenswood Road, Baltimore
Telephone: 655-6330

Russian

Mrs. Samuel Iwry
2401 Brambleton Road, Baltimore 21209
Telephone: MO 4-1153

Dr. Louis Blum
1190 W. Belvedere Avenue, Baltimore
Telephone: 433-1431

Mrs. Eugene Schnitzer (some)
3307 Terrapin Road, Pikesville 21208
Telephone: 486-4080

Rumanian

Mrs. Regina Knobler
3327 Clarks Lane, Baltimore 21215
Telephone: 358-9236

Mr. Marius Vogelfanger
3659 Forest Garden Avenue, Baltimore 21207
Telephone: 944-8559

Mr. & Mrs. Aurel Catulescu
116 W. University Pkwy, Baltimore
Telephone: 235-2580

Spanish

Miss Betty Adler (wheelchair case)
Marlborough Apts., Baltimore 21217
Telephone: 669-1892

Mrs. Stanley Klatsky
8510 Stevenswood Road, Baltimore
Telephone: 655-6330

Mrs. Morton Abramowitz
4705 Fallstone Road, Chevy Chase 20015
Telephone: 656-5876

Dr. & Mrs. Hugo Badel
1607 McGuckian Street, Annapolis 21401
Telephone: 268-8598

Swedish

The Swedish Consulate, Keyser Building
Baltimore
Telephone: 539-5061

Mr. Oddvar Nielsen
639 Piccadilly Road, Towson
Telephone: 823-4998

Reverend Asbjorn Nilsen
4313 Walther Avenue, Baltimore
Telephone: 254-7027

Tagalog (Philippines)

Mr. Steve Warres
3314 Fallstaff Road, Baltimore 21215
Telephone: 358-1151

Tamil (India)

Dr. Tapan Hazra and Dr. Meena Hazra
5104 Lodestone Way, Baltimore
Telephone: 488-3507

Dr. George Ramapuram
3207 Keyser Road, Baltimore 21208
Telephone: 484-4735

Telugu (India)

Dr. M. Krishna Reddy
Church Home Hospital, Baltimore (chief surgical resident)
Telephone: 732-4730 or 485-8983

Tripoli

Miss Clemence Genah (no car)
303 W. Northern Parkway, Baltimore 21215
Telephone: 358-9422

Tunisian

Miss Clemence Genah (no car)
3303 W. Northern Parkway, Baltimore 21215
Telephone: 358-9422

Turkish

Dr. Bedri Uzunalimoglu
Reed Hall, McElderry Street, Baltimore
Telephone: 342-8500, Ext. 489 (known as Dr. Bedri)

Visayan (Philippines)

Mr. Steve Warres
3314 Fallstaff Road, Baltimore 21215
Telephone: 358-1151

Yiddish

Mrs. Samuel Iwry
2401 Brambleton Road, Baltimore 21209
Telephone: MO 4-1153

Mrs. Lincoln Newfield
827 Lake Drive, Apt. K2, Baltimore 21217
Telephone: 523-4422

MEDICAL NEWS



In May, a group of Maryland physicians and their wives enjoyed a tour of the Eli Lilly Research Laboratories. Pictured are: Dr. and Mrs. A. Woody, Dr. and Mrs. S. Okutman, Dr. and Mrs. A. Rohrbaugh, Jr., Dr. and Mrs. C. Lee, Dr. and Mrs. Ellis, Dr. and Mrs. F. Jaggers, Dr. and Mrs. M. Edwards, Dr. and Mrs. I. Scher, Dr. and Mrs. C. Crimy, Dr. and Mrs. K. Lutlu, Dr. and Mrs. A. Aleece, Dr. and Mrs. H. Hall, Dr. and Mrs. G. Delgado, Dr. and Mrs. J. Ozaziewski, Dr. and Mrs. A. Estrada, Dr. and Mrs. N. McKay, Dr. and Mrs. R. Hernandez, Dr. and Mrs. S. Barranco, Dr. and Mrs. E. Jacobs, Dr. and Mrs. R. Salas, Dr. and Mrs. G. Palmer, Dr. and Mrs. P. Briscoe, Dr. and Mrs. E. Diaz, Dr. and Mrs. R. Barr, Dr. and Mrs. H. Harbold, Dr. and Mrs. W. Tyson, Dr. and Mrs. A. Siwinski, Dr. and Mrs. E. Cook, Dr. and Mrs. W. Birt, Dr. and Mrs. M. Byerly, Dr. and Mrs. L. Little, Dr. C. Gordon and daughter, Dr. H. Armanas, Dr. H. Ward, Dr. J. Fifer, Dr. P. Chang, Dr. S. Mahallati, Dr. G. Linsao, and Mr. and Mrs. J. M. Levine (Lilly representative).

MAGP Annual Meeting



Leon Berube, MD, out-going President of the Maryland Academy of General Practice; Ed Kowalewski, MD, newly installed President of the American Academy of General Practice, and William Stewart, MD, the new President of the Maryland Chapter posed for an informal photograph during the Maryland Academy's Annual Meeting in Warrenton, Virginia in May. Dr. Kowalewski was MAGP's special guest during the meeting. *(See pages 62 through 82 for some of the talks presented during the scientific sessions.)*

Ed Kowalewski, MD, was the special guest at the Annual Meeting of the Maryland Academy of General Practice, held May 9-11, 1969, in Virginia. Dr. Kowalewski is completing his term as president-elect of the American Academy of General Practice and will become president at the Academy's meeting this month.

At the May meeting, **William Stewart, MD,** was installed as the 21st President of the Maryland Academy of General Practice. A native of Baltimore, Dr. Stewart received his MD degree from The Johns Hopkins University School of Medicine in 1951.

Other officers elected at the Annual Meeting include: President-elect, John Chissell, MD, Baltimore; Vice-Presidents, Daniel Welliver, MD, Westminster; Hugh Ward, MD, Owings Mill; Hans Koetter, MD, Baltimore; Phillip Heu-

man, MD, Bel Air; Directors, Howard N. Weeks, MD, Hagerstown; George B. Patrick, Silver Spring; John B. Umhau, Jr., MD, Chevy Chase; Warren R. Lesch, MD, Bel Air; Frank Thomas, MD, Hancock; John C. Hyle, MD, Baltimore; James P. Jarboe, MD, Great Mills; Harold B. Plummer, MD, Preston; Secretary, G. Overton Himmelwright, MD, Cumberland; Treasurer, Harry L. Knipp, MD, Baltimore; Delegates to AAGP, Archie R. Cohen, MD, Clear Spring; Roy Guyther, MD, Mechanicsville; Alternate Delegates to AAGP, Robert Farr, MD, Chestertown; Leon W. Berube, MD, Mechanicsville; Executive Secretary, Mrs. Dorothy Holman, Baltimore; Editorial Board, William L. Stewart, MD, Leon Berube, MD, Dorothy Holman; Managing Editor —News Bulletin, G. Overton Himmelwright, MD; Publishing Editor, Bernard Sitter, MD.

* * *

A. Golpira, MD, has announced the relocation of his office on Cedar Lane to 3029 Dundalk Avenue, Baltimore, Md. 21222.

* * *

Jerome Sherman, MD, has moved his office to the Oxford House at 6810 Park Heights Avenue. Dr. Sherman specializes in the practice of allergy.

* * *

John B. De Hoff, MD, former director of local health services, has been named Deputy Commissioner of the Baltimore City Health Department. In this post, Dr. De Hoff will help chart the course of public health in Baltimore by assisting in the planning and direction of the total city-wide health program. His work will keep him in close contact with the city's medical profession and health-oriented groups in an effort to bring better health care to all Baltimoreans.

Dr. De Hoff received his BA, MD, and Master of Public Health degrees at The Johns Hopkins University. And by virtue of his life-long residence in Baltimore, and his experience, Dr. De Hoff is considered to be exceedingly well-qualified for his new position.

* * *

Emidio Anthony Bianco, MD, has been appointed Medical Director and Director of Medical Education at St. Agnes Hospital, Baltimore. In his new capacity, Dr. Bianco will be concerned with medical staff affairs, patient care, and direction of the medical education program of St. Agnes Hospital, administered by the Daughters of Charity.

Prior to assuming his post, Dr. Bianco had been the chairman of St. Agnes' Department of Medicine since 1967. He received his MD degree from Georgetown University and served an internship at St. Agnes Hospital. He completed his residency at the University of Maryland Hospital, where he was awarded a fellowship in Medicine.



Dr. Bianco

* * *

Robert R. Holthaus, MD, and William E. Schwartz, MD, announce the opening of their office for the practice of pediatrics at 7112 Darlington Drive (Oakleigh Medical Center) Baltimore, Maryland 21234.

* * *

J. Donald Woodruff, MD, has been added to the list of guest speakers for the District VI Meeting of the American College of Obstetricians and Gynecologists in Saskatoon, Saskatchewan, October 8-11, 1969. Dr. Woodruff is from The Johns Hopkins University School of Medicine.

* * *

William S. Spicer, MD, has been appointed consultant to the Dean of the University of Maryland School of Medicine for health care programs. Dr. Spicer's past experience as coordinator of the Maryland Regional Medical Program and as chairman of the Maryland State Board of Health and Mental Hygiene has enabled him to examine all aspects of health care in Maryland.

Dr. Spicer received his MD from the University of Kansas Medical School, and also trained in internal medicine at the University of Kansas Medical Center and at Fitzsimons Army Hospital.

* * *

The National Pituitary Agency, a University of Maryland-based agency that collects and processes human pituitaries for medical research, has named a new Director, **Salvatore Raiti, MD,** who will arrive here from

England on January 1, 1970. Dr. Raiti is presently senior lecturer in endocrinology at the Institute of Child Health in London.

Marvin Cornblath, MD, professor and head of the department of pediatrics at the University of Maryland School of Medicine, is serving as interim director of the NPA, following the resignation of the present Director, **Milton S. Grossman, MD,** who left to accept a position as chief of pediatrics and adolescent medicine at Mt. Sinai Hospital, Miami Beach, Florida.

* * *

Under the Federal Truth in Lending Act, which became effective July 1, 1969, a physician may be required to disclose, on statements sent to patients, the amount and terms of credit arrangements concerning his fees. Regulations issued under the Act apply not only to finance charges, but also to express agreements for payment of medical fees in more than four installments, either with or without finance charges.

Detailed information on the regulations may be obtained from the nearest Federal Trade Commission office or by mail from the agency's headquarters, Washington, D. C. 20580. The information is contained in a booklet entitled "What You Ought To Know About Truth in Lending Consumer Credit Cost Disclosure," Federal Reserve Regulation Z.

* * *

Elected Chief of the medical staff and chairman of the medical board of Church Home and Hospital is **J. H. Mason Knox, 3rd, MD.** As fifth chief of staff at the 111-year-old institution, he succeeds **James C. Owings, MD,** in both positions. Dr. Owings continues his association with the hospital as a senior staff member.

Dr. Knox, a general surgeon, graduated from Yale in 1934, and received his MD degree from The Johns Hopkins Medical School in 1938. During the second World War, Dr. Knox served with the 4th Auxiliary Surgical Group of the 3rd Army under General George Patton. A captain, he was in charge of a surgical team and earned the Bronze Star.

* * *

Irving H. Canfield, MD, has been appointed Deputy State Health Officer for Harford County by William J. Peeples, MD.

Dr. Canfield received his medical degree from Ohio State University and his Master of Public Health degree from the University of Pittsburgh.

The new Harford County Health Officer's office will be in the Harford County Health Department, 119 Hays Street, Bel Air, Maryland.

* * *

Governor Marvin Mandel has asked the nation's manufacturers of the DDT line of pesticides to eliminate dangerous elements from their products or face having them outlawed in Maryland. At the same time, the Governor announced that he intends to appoint a special committee to investigate the residual effects of all chlorinated hydrocarbon pesticides (DDT, Aldrin, Dieldrin, Endrin, and Heptachlor) on fish, wildlife, crops, and livestock.

Noting that DDT and similar pesticides have been "tremendously beneficial" to mankind, Governor Mandel said that evidence is rapidly accumulating that their potential harmful effects might far outweigh their benefits. The Governor also observed that Sweden already has prohibited the use of DDT and other types of this pesticide and that Arizona has declared a one-year moratorium on its use. Several other states have sharply restricted the use of DDT-type pesticides.

* * *

W. Bradley King, Jr., MD, and **Selvin Passen, MD,** have announced that **M. Wilson Toll, MD,** has become associated with them in the practice of Pathology at the Maryland General Hospital, 827 Linden Avenue, Baltimore, Md. 21201.

* * *

The following anesthesiologists in Maryland have been certified as Diplomates by The American Board of Anesthesiology: **Helmut F. Cascorbi, MD,** Baltimore; **Ralph A. Epstein, MD,** Bethesda; **Emil E. Pollard, MD,** Potomac; **Steven R. Wyte, MD,** Bethesda.

* * *

The Arthritis Foundation has announced the establishment of a permanent organization made up of interested nurses, occupational, physical and vocational therapists, medical social workers and others trained for work with arthritics.

The purpose of the organization is to keep these specialists informed of the new developments and techniques of their professions. Since it is sponsored totally by the Arthritis Foundation, there will be no dues or expenses of membership. Interested professionals should submit their names, addresses, and areas of special interest to Miss Janice Maynard, Chairman, Allied Health Professions Committee, The Arthritis Foundation, 12 W. 25th St., Baltimore, Md. 21218.

* * *

SAMPLE DISCHARGE SUMMARIES

Discharge summaries need not be lengthy nor consume the physician's time, contends Dr. Otto Arndal, Assistant Director of the Joint Commission on Accreditation of Hospitals.

In support of his contention, Dr. Arndal has prepared several sample discharge summaries, as follows.

DISCHARGE SUMMARY

Admitted. 1/9/69
Provisional Diagnosis:
Acute biliary colic

Discharged: 1/30/69
Final Diagnosis:
Cholecystitis-
Cholelithiasis

I. Brief History
Male, 55 years, admitted because of acute persistent pain in epigastrium and R. U. Q. of abdoman.

II. Pertinent Physical and Laboratory Findings
X-ray; non-functioning gallbladder.
B. U. N., blood sugar, liver profile and hematology: within normal limits.

III. Course of Treatment
Cholecystectomy: without drainage, inhalation anesthesia
Post-operative course uneventful.

IV. Condition on Discharge
Discharged in good condition; ambulatory.

V. Follow-up and Dicharge Medication
Pt. instructed to follow low fat diet; refrain from lifting and pushing. To call at office in 2 weeks. No medication given.

(Signed)

DISCHARGE SUMMARY

Admitted: 10/5/68
Provisional Diagnosis:
Fracture left femur

Discharged. 11/8/68
Final Diagnosis:
Fracture left femur
ASCHD with left heart-failure & coronary insufficiency

I. Brief History
Female, age 77, fell in home and sustained fracture of left femur. Pt. was confused at time of admission.

II. Pertinent Physical and Laboratory Findings
X-ray: intertrochanteric fracture of left femur.
ECG: left vent. ischemia.

III. Course of Treatment
Sensorium cleared. Pt. developed heart failure, was digitalized and operated uneventfully. Had several episodes of chest pain. Daily physiotherapy during last three weeks of stay.

IV. Condition on Discharge
Discharged to extended care facility via ambulance in satisfactory condition; using walker, bearing weight only on left toes.

V. Follow-up and Discharge Medication
Discharge medication: Digoxin 0.25 mg daily; Valium 2 mg. daily. Arrangements made for progressive physiotherapy at ECF.

(Signed)

DISCHARGE SUMMARY

Admitted: 12/16/68
Provisional Diagnosis:
Cerebral thrombosis with hemiplegia;
Hypertension;
Laceration scalp—left parietal area.

Discharged: 1/21/69
Final Diagnosis:
Same

I. Brief History
66-year-old woman treated previously for hypertension and right hemiparesis. Additional C.V.A.; fell and lacerated scalp.

II. Pertinent Physical and Laboratory Findings
2 cm laceration scalp (L); hemiplegia (L)

III. Course of Treatment
Scalp laceration repaired in emergency department. Only slight improvement under treatment with vasodilators, anti-hypertensive drugs; daily physiotherapy.

IV. Condition on Discharge
Basic cardiovascular status: unchanged—semi-ambulant, scalp wound healed.

V. Follow-up and Discharge Medication
Patient transferred to Chicago Rehabilitation Institute for further treatment; no medication given.

(Signed)

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number, the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestronol 0.1 mg.



The new mother needs time . . .
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contoins ethynodiol diocetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Orol contraceptian.

Contraindications—Thrambaphlebitis, thromboembalic disarders, cerebral opoplexy or a past histary of these conditians, markedly impaired liver functian, knawn ar suspected carcinoma af the breast, knawn ar suspected estrogen-dependent neoplasia, undiagnosed abnarmal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombatic disorders (thrambophlebitis, cerebrovascular disarders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reparted in April 1968[1,2] estimate there is o seven- ta tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral cantraceptives. In these controlled retrospective studies, invalving 36 reparted deaths and 58 hospitalizations due ta "idiopathic" thrombaembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusians reached in the studies ore summarized in the table below:

Comparisan af Martality and Haspitalizatian Rates Due to Thromboembolic Disease in Users and Nan-Users af Oral Cantraceptives in Britain.

Categary	Martality Rates		Haspitalizatian Rates (Morbidity)
	Age 20-34	Age 35-44	Age 20-44
Users of Orol Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

Na comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude af the increased risk to the individual patient, cannot be applied directly to wamen in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of visian, or sudden onset of praptasis, diplapia or migraine. Withdraw medicatian if papilledema or retinal vascular lesians are faund.

Since the safety of Ovulen in pregnancy has nat been demonstrated, it is recommended that pregnancy be ruled aut for ony patient wha has missed twa consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the passibility of pregnancy should be considered at the first missed periad.

A small fraction of the hormone agents in orol contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examinatian should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endacrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recammended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of pragestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctianal causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discantinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic ar uterine functian awaits further study.

A decrease in glucase taleronce has accurred in a significant percentage af patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens an epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes na absalute limiting factor, although Ovulen therapy may mask the anset of the climacteric.

The pathalagist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant assaciation has been shawn between use of oral contraceptives and the following serious adverse reactians: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive af an association, such a relatianship has been neither confirmed nar refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-acular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and blooting), breakthrough bleeding, spotting, change in menstrual flaw, amenorrhea during and after treatment, edema, chloasma ar melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosian and cervical secretians, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depressian.

Although the following adverse reactians have been reported in users of aral cantraceptives, an assaciation has been neither confirmed nor refuted: anovulatian post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nadosum, hemorrhagic eruption, itching. The following labaratory results may be altered by oral cantraceptives: hepatic function: increased sulfobromaphthalein and other tests; coagulatian tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein baund iadine, and decrease in T^3 uptake values; metyrapane test; pregnanedial determinatian.

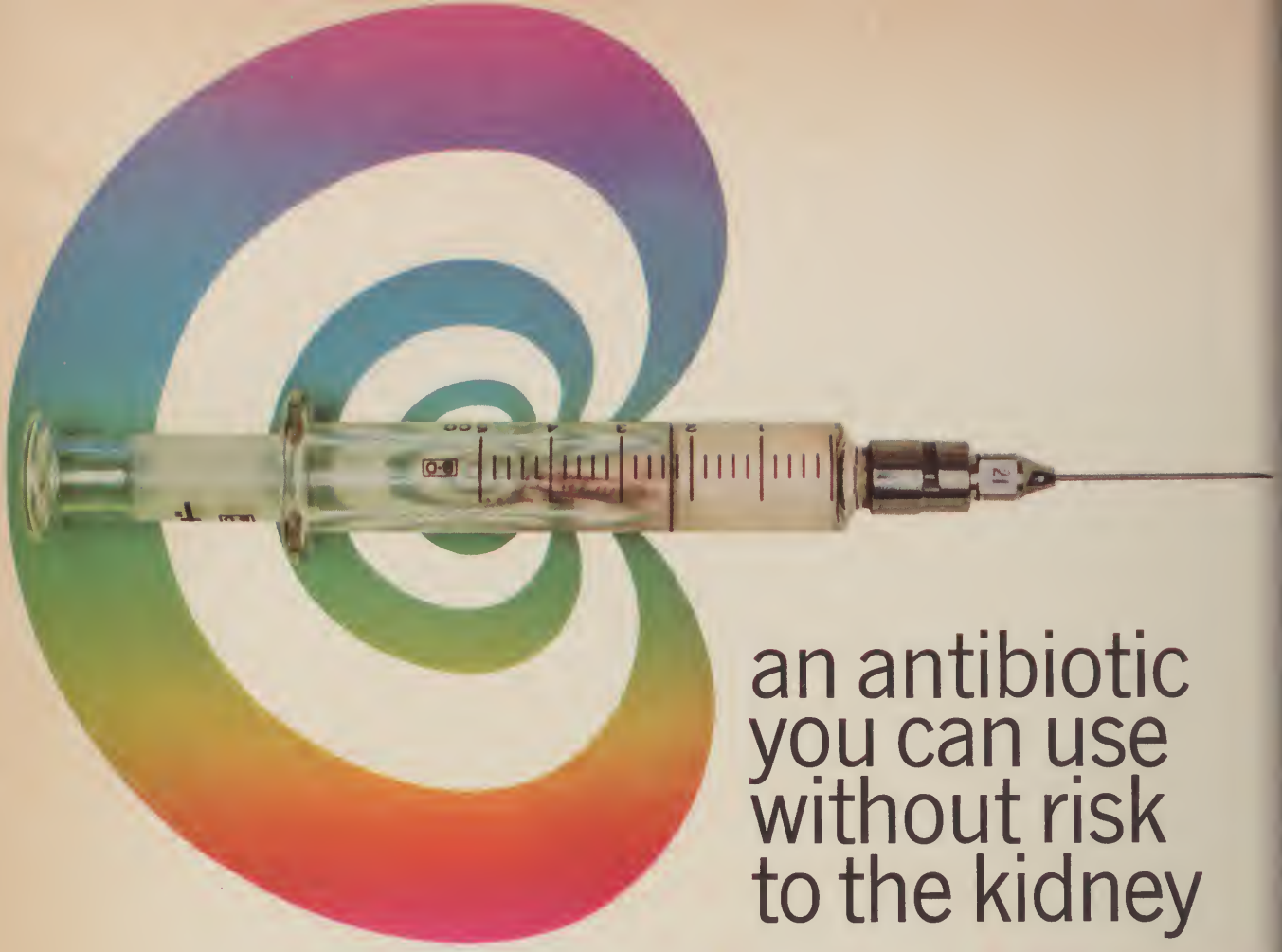


References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing informatian.

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE



an antibiotic you can use without risk to the kidney

Polycillin-N

(sodium ampicillin)

the penicillin you use like a broad-spectrum antibiotic

PRESCRIBING INFORMATION. 11—1/2/69. For complete information consult Official Package Circular.

Indications: Infections due to susceptible strains of Gram-negative bacteria (including Shigellae, *S. typhosa* and other Salmonellae, *E. coli, H. influenzae, P. mirabilis, N. gonorrhoeae* and *N. meningitidis*) and Gram-positive bacteria (including streptococci, pneumococci and nonpenicillinase-producing staphylococci).

Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions: Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

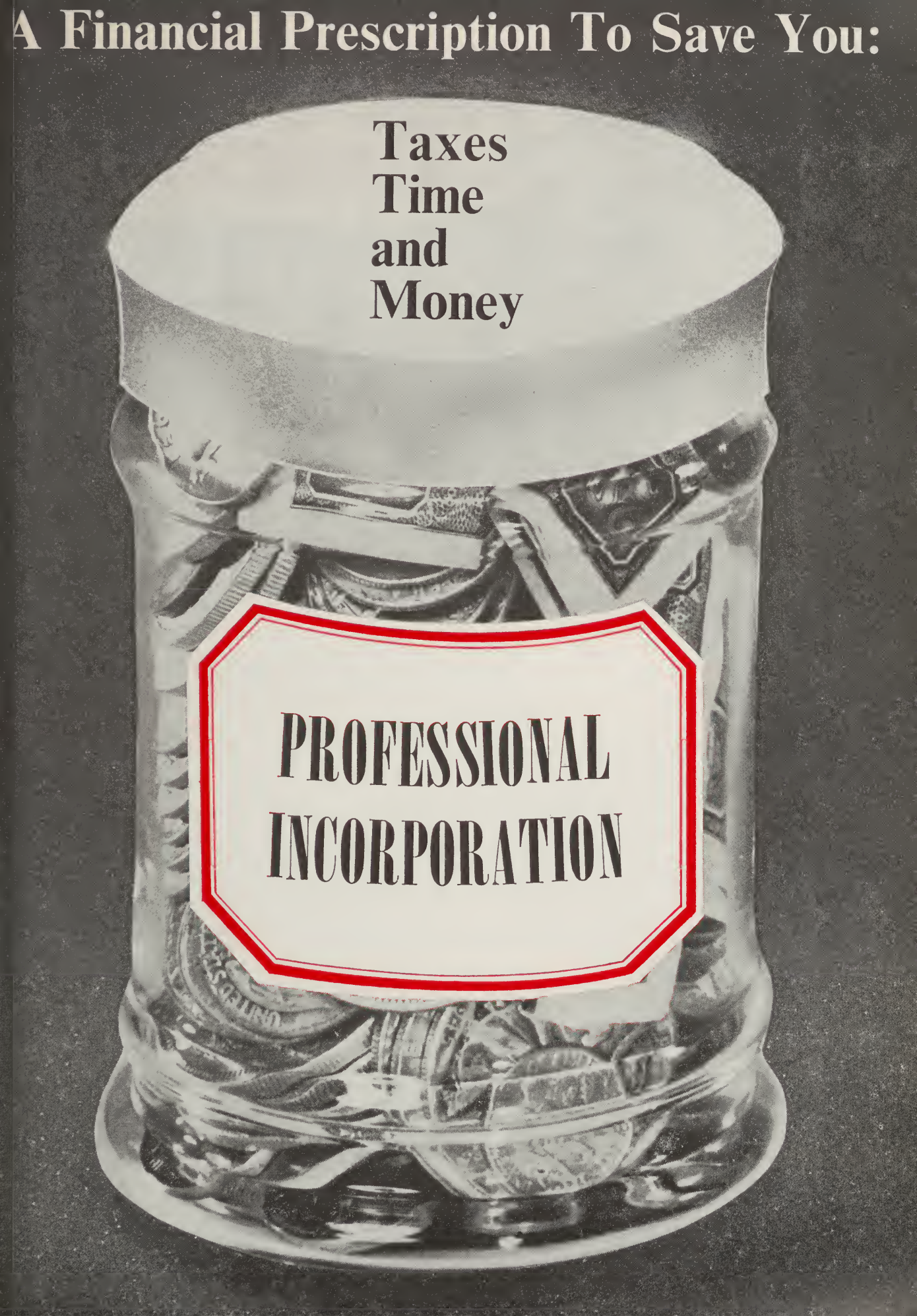
Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

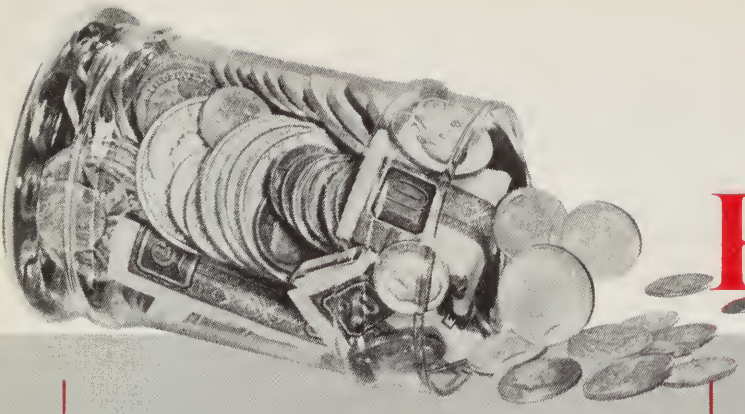
Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles. **A.H.F.S. Category 8:12.16**

BRISTOL

BRISTOL LABORATORIES
Division of Bristol-Myers Company
Syracuse, New York 13201

A Financial Prescription To Save You:





Incorporate Professional

Professional Corporations Get Green Lights

On July 1, 1969 the Maryland Professional Service Corporation Act became effective. It permits physicians, dentists, laywers, and other professionals to incorporate and become eligible for all the benefits of corporate employees.

On August 8, 1969, the Internal Revenue Service, after opposing professional corporations for many years, announced "it is conceding that organizations of physicians, dentists, lawyers and other professional people, organized under state professional asssociation acts, will, generally, be treated as corporations for tax purposes.

What Incorporation Does For You:

- ☐ **A Corporation Pays Much Lower Taxes— 22% on the first $25,000 of taxable net profit, 48% on taxable net profit in excess of $25,000.**
- ☐ — You may contribute much more than the extremely limited proportion of your income now permitted under HR10 (The Keogh Act). Contributions to the fund are fully tax deductible. Investment income earned by the trust is exempt from income taxes. As trustee, you may select your own investment.
- ☐ **Defer Participation in the Profit-Sharing Plan for up to five (5) years.**
- ☐ **Postpone ownership of participant's funds.**
- ☐ **Group life and health insurance.**
- ☐ **Medical payment plans.**
- ☐ **Disability income programs.**
- ☐ **Deferred compensation agreements, stockholder's agreements in conjunction with your personal estate plan.**



nder Maryland's New
ervice Corporation Act

Reduced Taxes = Reduced Personal Liabilities

Under the statutes provided by The Maryland Professional Service Corporation Act, you as a corporate employee, are protected by established limits of liability (except malpractice). The members of the corporation are not personally liable for the debts, liabilities or contractual obligations of the corporation.

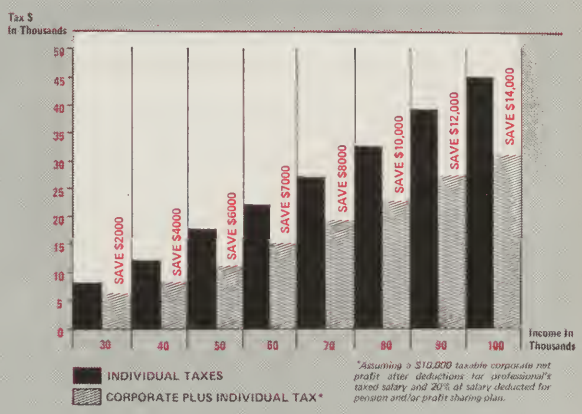
If you earn less than $40,000 per year . . .

Don't Incorporate

Incorporation is a complex process, and the adoption of a pension and/or profit-sharing plan acts as your tax shelter. Unless you can save at least $2000 in taxes, the time and expense involved in incorporation is not warranted!



Savings At Various Salary Levels



Why A Professional needs a Professional when incorporating

You are highly trained and skilled in your field. No ordinary citizen could perform the services which you proffer. The same is true of financial planning. You need an expert to guide you. You need Professional Associations Division.



Why professional managemen

Professional Associations Division was organized specifically to help professional men take best advantage of the new Maryland Professional Service Corporation. Qualified experts in the field of financial management, pension and profit-sharing plans, exempt sick-pay plans, and tax-free group life insurance plans serve on our staff.

Our experts aid your attorney, accountant or other financial advisors in the formation of the profes–sional corporation. We will assist you and your con-sultants in developing pension and profit- sharing plans which qualify for preferential tax treatment under the Internal Revenue Code.

The invaluable service we offer you, and it is unique in this area, can save you thousands of dollars–and many hours of your valuable time. In consideration for our services, Professional Associations Division charges a fee of $250.00 and stipulates that any mutual fund or insurance investments selected by the trustees be obtained through Professional Associations Division.

Professional Associations Division prescribes a generous dose of financial planning to make your professional corporation, and your financial future, strong and healthy!

Want to find out more about this opportunity for tax shelters? Professional Associations Division is sponsoring a seminar, preceded by cocktails and buffet on "Professional Corporations– The New Laws" on Wednesday, October 15th 1969 at the Baltimore Statler-Hilton Hotel at 7:00 P.M. This seminar is especially designed to acquaint you with this new legislation.

pa

Professional Associations Division
A Division of Insurance Management of Washington, D.C., Inc.
1025 Connecticut Avenue, N.W.
Washington, D. C. 20036
Telephone (202) 223–2225

pa

Professional Associations Division
1025 Connecticut Avenue, N.W. • Washington, D. C. 20036

Sirs:

☐ I am interested in Professional Corporations and would like to attend the seminar, Wednesday, October 15, 1969, Baltimore Statler-Hilton Hotel, 7 P.M. Reservations Necessary.

☐ I am interested in Professional Corporations, but can not attend the seminar.

NAME _____

ADDRESS _____

CITY _____

STATE _____ ZIP _____

PHONE _____

MED-CHI TOURS

The Medical and Chirurgical Faculty is sponsoring two exciting tours in the near future:

FIESTA IN SPAIN—October 31 to November 8, 1969

A deluxe all-inclusive tour leisurely exploring the wonders of the romantic country of Spain.

ORIENTAL CARNIVAL—May 1 to May 17, 1970

A fabulous deluxe tour leaving from Friendship Airport. This, too, is all-inclusive with six fun-filled days and nights in Tokyo, seven glorious days and nights in Hong Kong, three enchanting days in Honolulu. An opportunity is provided to visit the fabulous 1970 Japan World Exposition in Osaka via the famous "Bullet" train (140 m.p.h.). Included are sightseeing tours, a get-together cocktail party, dinners in restaurants of your choice, breakfasts, and many other attractions.

Make your reservations NOW: For information and reservations contact Mrs. Beverly Wolins, Travel Guide Agency, 416 North Charles Street, Baltimore 21201 (301-727-0680) or Mrs. Genevieve Ritchie, the Faculty office, 1211 Cathedral Street, Baltimore 21201 (301-539-0872).

GUEST EDITORIAL . . .

Service Program —

American Cancer Society, Maryland Division, Inc.

When cancer strikes, the American Cancer Society helps.

This statement is the theme of a state-wide public information campaign to focus attention on the Society's program of service to cancer patients in Maryland.

The American Cancer Society wants to help, but in too many instances there is no request. Since the physician plays a most important role in caring for cancer patients, the Society's objective is to keep the medical profession informed of the various services available. It is hoped that physicians will suggest to their cancer patients or families that they call their local Unit of the American Cancer Society for information and counseling.

As stated in the Maryland Division's brochure, *People Helping People,* "A cancer patient frequently needs help—lots of help. The American Cancer Society feels that to help cancer patients and their families is an important part of the Crusade to conquer this disease. . . . Many services are available to all cancer patients, while others are limited to those who need financial assistance. However, there is never a charge for any service provided by the Society. . . ."

The Maryland Division is committed to a program of financial assistance to the cancer patient and has established a comprehensive program of varied services to meet the needs of cancer patients in the State. The program is administered at the local level by Unit volunteer service committees in each of the 23 counties and Baltimore city. The Unit (county) Service Chairman and Committee arrange for those services which are available upon request to all cancer patients. An application is not necessary for these services. The Service Committee also distributes, and in turn receives, reviews, and approves all applications for services which require financial assistance.

The Maryland Division, through its Units, does not have unlimited funds available for the Service Program. A patient's eligibility is determined by the Unit Service Committee, after reviewing all facts supplied in the application for financial assistance. The American Cancer Society feels that this flexibility is necessary since the definition of "medically indigent" varies greatly throughout Maryland.

Every effort is made to assist each cancer patient in some way, depending upon the degree of the patient's need. Often, due to their experience and knowledge of other community resources, the Unit Service Committee is able to obtain assistance from community agencies or organizations, or both, with which the patient or family may not be aware.

Patient services are those services available to cancer patients in the home and are intended to relieve some of the physical, emotional, and financial problems which most often accompany cancer.

The following services are available to all cancer patients upon request:

Information and counseling

Surgical dressings

Sickroom equipment such as hospital beds, wheelchairs, blenders, walkers, portable commodes, etc.

Financial assistance is provided for the following services to eligible cancer patients (the patient or family must submit an application for assistance which is available from the Unit Service Chairman):

Medications

Visiting Nurse services

Rehabilitation program

Room and board while receiving outpatient treatment

Homemaker services

Laboratory services (limited)

Transportation (when volunteer transportation is not available)

The following services are not provided for under the program:

Physicians' and surgeons' fees

Hospital care costs

X-ray therapy

Clinical services

Nursing home services

Additional information about the American Cancer Society, Maryland Division Service Program may be obtained by contacting the local American Cancer Society Unit listed in the telephone directory.

EDWARD A. SAWADA, MD
Chairman, Service Committee
American Cancer Society
Maryland Division, Incorporated

Psychiatry for the Family Physician

The Maryland Academy of General Practice held its 21st Annual Scientific Assembly at the Airlie Foundation in Warrenton, Virginia from May 9-12, 1969. This year we chose as our theme "Psychiatry for the Family Physician."

Psychiatry touches every facet of family practice and, in many ways, is a cornerstone for this type of practice. Wittingly or unwittingly, every physician who sees patients practices psychiatry. The mere giving of a prescription has marked psychiatric implications. After all, doesn't this imply that the physician knows what is wrong and the medicine he is prescribing is what is needed to effect a cure?

As we conquer more of the physical diseases to which man falls heir, and as our society becomes more complex, it seems that the Pandora's box of emotional illnesses opens wider all the time. It seems certain that psychiatry for the non-psychiatrist will become increasingly important in the immediate future.

The approach of the symposium on psychiatry began with behavior problems in children and ended with the problems of senesence. We heard talks about adolescence, the crisis of the middle years and conjoint family therapy, as well as sex education.

Of particular interest and outstanding value, was the movie produced by Dr. Murdock Head, at the Airlie Foundation, entitled *THE DISTANT DRUMMER*. This film, a documentary which deals with narcotics addiction, has been seen on television on a nation-wide basis. This film should certainly be seen by every member of the medical profession.

Another timely talk dealt with some of the problems of our national disgrace—the urban ghettos. These are problems which keep drawing national attention with increasing insistence—problems which can no longer be denied. Solutions to these problems certainly must be found if we are to survive as a nation.

It is readily apparent that a great deal of material was covered in a day and a half. It is difficult to measure the success of a meeting such as this; but if one leaves with one new thought or one new way of looking at things, then for him the meeting was worthwhile.

Since its inception, the American Academy of General Practice has been dedicated to the concept of continuing education. The extent to which the individual members support such activity validates the purpose of the Academy. The Academy is the only professional organization that requires regular participation in postgraduate education. The American Board of Family Practice is the first specialty board to require periodic re-examination and recertification. It seems rather certain, however, that some universal method of insuring continuing professional competence is only around the corner.

A special word of thanks is due our speakers for giving so generously of their time and talent and to the drug firms, Roche Laboratories and Merck Sharp and Dohme, for financing this outstanding symposium.

WILLIAM L. STEWART, MD
President
Maryland Academy of General Practice

The following papers were presented during the Annual Meeting of the Maryland Academy of General Practice, May 9-12, 1969, Warrenton, Virginia.

THE DRUG ISSUE

MURDOCK HEAD, MD
Professor and Chairman
Department of Medical and Public Affairs
George Washington University Medical Center

For the last two years our camera crews have traveled around the world through various cities filming transient American youth from Kat Mandu in India to the Gulf of Aqaba in Israel.

The drug problem plays a large part in the unrest among our youth. It is also a focal point for crime. The drug problem is going to get larger for those of you who practice in urban areas. It is even beginning to surface in rural areas. In Madison, Wisconsin, a year and a half ago, a junior high school was "busted" by the police. At that time they found ten- and twelve-year-olds both "pushing" and using marijuana.

The drug picture breaks down like this: Basically, marijuana is the drug for the young, and it is fed by the amateur. The Mafia does not involve itself with marijuana. For one thing, it cannot compete with the youngsters who hollow out surf boards, carry it in ice cream cones, or bicycle seats. You can grow marijuana any place. Marijuana, as you probably know, is a product of the plant, *cannibis sativa,* which is the female of the hemp family. Students in boarding schools can grow it in their flower boxes; farmers grow it between rows of corn.

Uncle Sam must assume some of the responsibility for the marijuana problem. During World War II, the farmer was encouraged to grow *cannibis* for hemp to be used by the Navy. He was encouraged to plant it wherever it would grow, and, as we have already noted, it will grow almost anywhere.

As revealed in the film, *THE DISTANT DRUMMER,* the strongest marijuana comes from the Tropics. The kids will pay as much as a dollar for what they call the "golden stick" or "Acapulco Gold." Marijuana is called by many different names. In North Africa, for example, it is called "kief." Farmers there can make more money by growing "kief" and trading it for cooking oil, staples, salt and meat, than they can in trying to euchre crops from an impossible terrain. Countries in which poor farmers require the basic necessities of food and ordinary comforts can fare much better by raising marijuana, than they can with ordinary crops. The countries in which this situation exists are the *producing countries.* The second element in the equation is the *consumer country.* The United States is a tremendous consumer of drugs, not just marijuana, but tranquilizers, sleeping pills, and many others. This country is on a drug binge. When there are producing areas and consumer areas, then "money" becomes the name of the game. The cornerstone of the drug problem is money, money, money.

I am not a psychiatrist. I will not attempt to analyze this aspect of the drug problem, nor to discern the motivation of youth to take it. I might point out, however, that youth is revolting. What are they revolting against? They are revolting against

The problems of the inner city are directly related to the environment. A great many of our concerns, particularly in the psychiatric area, are related to the environment. The drug issue is one of these.

us in the establishment—they do not like what we do. They believe we are hypocritical. They do not adhere to our economic objectives, our sexual mores, our sociocultural norms. They want to "cut out." They are also protesting Viet Nam. This is a War that nobody likes. They are revolting against all sorts of things, but in Sweden where there has been no war for 200 years, and cradle-to-the-grave security, there are 10,000 registered adolescent amphetamine addicts. Amphetamines were brought into Sweden by the German army, who used them early in the War to give the troops courage. Sweden has one of the highest rates of drug addiction in the world, the highest suicide rate, one of the highest divorce rates, the highest rate of alcoholism, and one of the highest instances of duodenal ulcers in the world.

I have spent two and a half years in the back alleys and the ghettos of the world, but I can assure you, the drug problem is as much a middle-class problem as it is a ghetto problem. Heroin *is* basically a ghetto problem. People in the ghettos want to get out any way they can and heroin is the quickest road out. Marijuana may be used at one time or another by 50% of the students in universities. They are not always potheads and they do not always move to heroin. I do not wish to enter into the argument of whether or not marijuana is addictive, or whether or not it is a physical or psychological problem. I can tell you I have seen many users, and if there is a *psychic dependency* upon this or any other drug, including alcohol, there *is* an element of addiction.

The drug problem is very much with us. There is one major truth we must face; as long as there are kids in the ghettos taking drugs and we enforce the law, they may be given four years for possession, and up to forty years for pushing. Addicts must steal $500 a day retail, to resell it to a fence for $100 to feed their habit. Few Americans really care what happens to these addicts. However, when the law invades a middle-class high school where your and my sons and daughters are, there is trouble in enforcement.

My 12-year-old daughter can buy "pot" in the girls' room in her junior high school anytime she wants to walk in and get it. Many of you don't believe this happens. I can assure you it does happen and I can promise you there is more alienation between our children and us than we know. How many of you with teen-agers can talk to them? Do you get through to them? Can they get through to you? This is the real problem of the middle class. If we enforce the law in the suburbs, we must arrest the sons and daughters of physicians, judges, and important business men. These students can also get four years for possession and forty years for pushing. We have laws on the books that the police officials are obligated—in theory—to enforce, but they cannot "equally" enforce them. There is a real dichotomy here. You cannot legislate morality, so we are faced with a real conflict of law in dealing with marijuana, the psychedelic drugs, and the amphetamines, as well as hard drugs.

You people see these problems at the first level, and need to gain sophistication about drugs. You must know a great deal more about drugs than you do. My role as a communications professional—as an educator turned propagandist—is to attempt to bridge between what is known in research and what you physicians are practicing. Don't forget the word *consumer*. You call him a patient, a lawyer calls him a client. These consumers are a sophisticated group, particularly the young ones who, according to Marshall McLuhan, have watched 4,000 hours of television before they begin school. These children are alienated and restive. As they become more restive, Congress hears about it, and when Congress is stirred, it acts. We physicans must take a leadership role, not only in drugs, but across the board in medicine, to affect the direction of American medicine. Each of the issues that disturbs the consumer, such as drugs, must be of concern to us. I believe it is extremely important that in your Academy you make yourselves available to speak to high schools, to university groups, to Kiwanis clubs, to Rotarians—anywhere you can. Be there and try to reach the consumer. I encourage you to talk to your elected officials. I encourage you gentlemen to move into the 20th century and talk about the problems that are concerning our citizens, while, at the same time, stay in touch with your officials.

I hope you will watch for the first of our television series on drug abuse. It is entitled *A MOVABLE SCENE* and is narrated by Robert Mitchum. It will appear in over 100 television stations, in schools, in community organizations, and elsewhere.

RECOGNIZING THE SUICIDAL PATIENT

Depression is a serious systemic disease with psychological and physiological expression, of which suicide is very much a part. The person seriously contemplating suicide does this from a sense of profound despair and feeling of hopelessness. The diagnosis of despair is a difficult and elusive one, and we must listen attentively with "the third ear" to tune it in. The doctor must pay attention to his patient's social nutrition and to the feelings the patient arouses in him. Once convinced that the patient wants to die and is making plans, secrecy should be swept away and the patient's isolation attacked. If in doubt, hospitalize.

BERNARD R. SHOCHET, MD, FACP
Acting Chief
Department of Psychiatry
Sinai Hospital of Baltimore, Inc.

Depression is a prevalent, systemic disease ranging in severity from a mild neurotic reaction to the profound retardation or restless misery of severe melancholia. Depressive states are also encountered as effective equivalents—periodic spontaneously remitting physical illnesses, such as, rheumatism, asthma, peptic ulcer, and dermatitis. Because of the frequent occurrence of somatic complaints, the depressed patient usually turns to the family physician before making serious self-destructive attempts.

Depression is a terrifying disease. It begins insidiously with feelings of apprehension and despondency. It is almost impossible to pin point when the illness begins. It may progress to a state of severe agitation or profound apathy. There is global somatic dysfunction, as well as inability to perform ordinary tasks. There are usually characteristic vegetative disturbances, such as, sweating, flushes, dryness of the mouth, constipation, weight loss, and early morning rising. The depressed patient will feel his worst in the morning but may improve as the day wears on.

Characteristics of Depression

1. **Lowering of mood**
2. **Slowing of thought processes**
3. **Slowing of muscular activity**
4. **Vegetative disturbances**
5. **Feelings of guilt and worthlessness**
6. **Somatic complaints**

It has been postulated that in depressive illness there is a neuro-physiologic disturbance in the amygdala and associated reticular formation relating to an abnormality in catecholamine metabolism. Psychologically, there is a real or threatened loss of a love object and an incapacity to reinvest this energy into other objects. This leads to withdrawal from the world, combined with self-accusation and guilt. There is an associated decrease in self-esteem and intense feelings of helplessness and hopelessness.

Early in a depression, the patient has a pervasive feeling that something is wrong. This is usually focused on some physical experience or concern.

There are the associated vegetative symptoms of early morning rising, anorexia, weight loss, and constipation. The blood pressure may be elevated. The patient may or may not be able to verbally express his feelings of guilt and concern about his life problems.

Depression may occur during any period—including childhood and adolescence. This may herald a schizophrenic illness or be the beginning of a life long manic-depressive illness. In adolescence and early adulthood, this may represent the response of an immature personality to the increasing responsibilities and frustrations of adulthood and may lead to suicidal gestures. Thus, suicidal gestures and depression in adolescents and young adults may reflect quite different kinds of emotional illnesses.

Usually in unstable and immature young people, there is no great threat to life. The problem is primarily one of immaturity and impulsiveness in the face of an acute situational problem. On the other hand, psychotic illnesses in this age group may be heralded by depression or suicidal gestures.

Failure to correctly evaluate a depressive illness in an older adult is a serious error, as this group constitutes the greatest suicidal risk. The patient usually does not complain of depression or suicidal intent, and the physician must elicit this information by asking specifically about the patient's sleep pattern, spirits, outlook, and suicidal intent.

Occurrence of Depression

A. Childhood and Early Adolescence
- **1. Beginning of schizophrenic illness**
- **2. Beginning of manic-depressive illness**

B. Late Adolescence and Early Adulthood
- **1. Immaturity**
- **2. Increasing responsibilities**

C. Middle Age and Older
- **1. Greatest suicidal risk**

Symptoms of depression include depressive feelings, expressed or implied, shifting and diffuse somatic symptoms, agitated motor behavior, self-depreciatory thoughts, and the aforementioned vegetative signs. Suicide is part of this syndrome.

Prior to the depressive illness, the patient usually has manifested a compulsive character disorder. He is responsible, conscientious, hyperindependent, someone to confide in—a support of the world. He manifests outstanding qualities of reserve, integrity, steadiness, and uncomplainingness. Frequently, there is a history of loss of a key family member in the patient's early years.

Pre-Morbid Personality

1. **Compulsive character structure**
2. **Responsible**
3. **Hyperindependent**
4. **Takes care of others**
5. **Uncomplaining**

Certain organic illnesses present with depression, such as, chronic pancreatitis, carcinoma of the body of the pancreas, brain tumor, chronic toxic states 2° to the chronic ingestion of bromides or barbiturates, and prolonged treatment with high dosage of reserpine and many endocrinopathies. Depression and precipitate suicide may occur with the use of drugs, particularly with LSD.

Organic Illnesses Associated with Depression

A. Pancreatic Disease
- **1. Chronic pancreatitis**
- **2. Carcinoma of Body of Pancreas**

B. Brain Tumor

C. Chronic Toxic States
- **1. Bromides**
- **2. Barbiturates**

D. High Dosage of Reserpine

E. Endocrinopathies

Suicide is part of the syndrome of depression. It is the 12th most common cause of death in the United States, the ratio of attempted to successful suicide being about 8:1. Suicide is also the second highest cause of death in the adolescent age group.

Suicide is the final common pathway of diverse circumstances. Most people have had suicidal thoughts or even suicidal impulses. These are most frequent in adolescents, but no time of life is free of them.

The person considering suicide is always ambivalent—he wishes to live at the same time as he wishes to die, and because suicide is a cry for help, the potential victim will almost always signal his intention. The cry for help is often disguised or in code, so the potential rescuer must be able to interpret it.

There are usually some verbal or behavioral clues as to intent, which may be conscious or unconscious appeals for help before the suicidal act occurs. It has been reported that more than half of those committing suicide had seen a physician within three months of the event and 25% had had psychiatric contact. Many studies point to a disruption of close personal relationships as being the main precipitating factor in suicidal behavior.

There are certain groups in which the risk of suicide is considerably higher than among the general population. In the aged, high risk is correlated with mental ill health, social isolation, death of a loved one, or loss of social role. On the other hand, personal and domestic problems are associated with the high rate of suicide in younger age groups, and many studies reveal a high incidence of broken homes early in youth.

There is a particularly high incidence of suicide accompanying depressive illness, especially when endogenous. The occurrence of successful suicide,

within one year of an aborted attempt, is well documented. Eight out of ten people who successfully commit suicide have previously attempted or threatened suicide.

High-Risk Groups for Suicide

1. **Depressed patients**
2. **Chronically ill and isolated**
3. **Bereaved**
4. **Previous suicide attempts**
5. **Previous suicide threats**
6. **Current verbal or behavioral declarations of suicidal intent**

The vast bulk of suicidal attempts spring from despair and helplessness before a life crises. Many people fail to express despair openly. Instead, they respond to helplessness in ways that make their desperation unrecognizable. Despair can be as difficult and elusive to diagnose as the most difficult disorder or disease that is encountered in general medicine.

In the recognition of suicide the doctor must use all available information. The psychological processes that lead to suicide are obscure: It is the secrecy and stealth that make the diagnosis so difficult.

The doctor must observe the patient for objective signs and symptoms. He must gain an understanding of the environmental ecology of the patient—his *social nutrition*. He must try to understand the inner experience of the patient and he must be aware of the feelings elicited in himself by the patient. Feelings are contagious and so the physician has an instrument within himself to detect the concealed despair in his patient. He then must evaluate all this data from various sources and decide what psychologic processes are at work: What is bizarre, what doesn't fit?

Recognizing the Suicidal Patient

1. **Observation for objective signs**
2. **Evaluation of social nutrition**
3. **Evaluation of inner experience of patient**
4. **Awareness of feelings elicited in himself by the patient**

The physician may be annoyed or saddened by angry or depressed people. We should be aware that our own reactions of this nature are part of this clinical picture. Beware of depressed people who recover suddenly without obvious reason. The patient may have decided to die. Pseudocheerfulness can also lead us astray.

The patient should be asked if he wants to die; a flat denial is not to be accepted at face value, especially if the doctor discerns persistent hopelessness in the patient. The physician should ask himself, "Does the patient feel his life is now worth living?" Another issue of great importance is whether anyone wants the patient to live. The patient may be unwittingly and unconsciously invited to suicide by a key family member. What is the condition of the patient's social nutrition?

The physician's first task is to form a relationship with the patient. The second is to be able to accept what that relationship reveals. Our job is to clarify—not to reassure or criticize—and to try to make the patient feel understood, and to discuss what matters are powerful sources of encouragement to him. A sense of isolation is very dangerous for the depressed person. The physician should try to convey to the patient that he understands how badly the patient feels.

First Aid for the Potential Suicide

1. **Form a relationship with the patient**
2. **Be able to accept what is revealed**
3. **Attack the isolation of the patient**
4. **Give only small quantities of medication**
5. **Involve the family**
6. **Psychiatric hospitalization if safety is in doubt**

If the physician thinks suicide is a definite possibility, large amounts of medication should not be given to the patient. A definite return appointment should be given. The family should be involved as soon as possible in the planning for the patient, just as in any other medical emergency. Successful suicide thrives on secrecy. If the family situation seems weak or unsupportive, or if for any reason the physician feels uncomfortable or very concerned about the patient's safety, hospitalization in a psychiatric facility should be insisted upon and accomplished rapidly. This will prove to be a relief to the patient and the family.

After all this is said, there will be a certain number of patients who are especially determined and especially secretive and who will act on their decision to die. This can be a sobering experience indeed.

REFERENCES

1. Miller; Fellner; and Greenfield: Depression, Suicide, and Suicidal Gesture in Medical Practice, *Ann Int Med* **51:**78, 1959.
2. Miller, and Fellner: In the Guise of Organic Disease, *Am J Med* **32:**495, 1962.
3. Havens, Leston: The Anatomy of a Suicide, *New Eng J Med* **272:**401, 1965.
4. Havens, Leston: Recognition of Suicidal Risks through the Psychologic Examination, *New Eng J Med* **276:**210, 1967.
5. Shochet, B. R.: *Brief Psychotherapy in the Medical Office, Modern Treatment,* New York: Hoeber-Harper, 1969.
6. Shochet, B. R.: Attempted Suicide: Experience in a General Hospital Emergency Service, *Md State Med J* **13:**107-112 (No. 3) 1964.
7. Hodern, A.: The Antidepressant Drugs, *New Eng J Med* **272:** 1159, 1965.
8. Prevention of Suicide—Public Health Papers #35 World Health Org, Geneva 1968.
9. Cohen, I. H.: *Masked Depression in the Medical Patient, Modern Treatment,* New York: Hoeber-Harper, 1969.

Behavior Disorders in Children

RUTH W. BALDWIN, MD
Associate Professor of Pediatrics
Director of the Clinic for the Exceptional Child,
University of Maryland School of Medicine



In the past 20 years, especially in the last five years, much has been written about organic behavior disorders or brain damaged children under some 38 different terms, such as, Minimal Brain Damage, Minimal Brain Dysfunction, Brain Injury, Brain Damage, Hyperkinetic Syndrome, and Percentually Handicapped. Behavior problems, formerly considered emotional ones, are now being recognized as organic in origin.

Diagnosis may be made by history of abnormal behavior, soft signs in neurological examination, abnormal psychological evaluation, and abnormal electroencephalograms. Treatment must be three-prong—medical management with various medications, counselling, and educational planning.

Etiology

Many physicians, sociologists, and psychologists have considered behavior and learning disorders to be closely associated with child rearing and interpersonal relationships. Recently, it has become popular to attribute these problems to socioeconomic, environmental factors, especially since many of the problem children dwell in the poorer inner-city areas. Psychiatrists have been and still are treating these children primarily as emotionally disturbed.

Even so, it is easy to find some rejection, hostility, overprotection, or sibling rivalry in any home. Yet, few professionals have considered what the child has actually done to produce the antagonism in his parents or siblings or both.

Although no figures are available, heredity and prenatal, perinatal, and early neonatal factors must be considered since reports describe many of these children as exceptionally active, irritable babies, frequently with sleep problems. Many require little sleep and are head bangers or rockers, etc. Severe illnesses, infections or head injuries may be primary causative or additive factors in behavior disorders in children.

Symptoms

The symptoms may be either above or below the range of normal. The most usual complaint is hyperactivity. These children are in constant motion. They sit for only a few minutes and are off again. Activity in the younger children is purposeless and, although it is more organized in the older children, it is disruptive and destructive. Their movements are jerky and quick, and they appear clumsy and awkward. Choreiform, athetoid movements have been observed. They can't keep their hands to themselves, but must have them on others when not busy.

The next most frequent complaint relates to their social adaption. They have few or no friends among their peers and are pushed aside. They may be aggressive and instigate fights, but some won't try to protect themselves. They are followers with older children and will commit antisocial acts at their urging. They adjust well with younger children by being the boss. Behavior can be termed immature.

These children can be mean with rapid mood swings—temper tantrums or rage reactions. They are stubborn and defiant, then apologetic and remorseful, only to repeat the same antisocial or defiant act. Some seek approval and want to be told they are loved. They want to hug or kiss those in close proximity, but will hug with a death-like grip or suddenly pinch. Feelings are easily hurt and crying is excessive. They are easily frustrated and act out. Impulsive behavior may lead to stealing, lying, fire setting, and story telling which may be misunderstood as hallucinating.

Attention span is short and they are easily distracted. These children are slow to complete an assignment or fail to do so. Concentration is poor. They may be persistent, either verbally or in motor activity. Some tend to be perfectionists, redoing papers over and over and finally becoming frustrated and angry.

Learning disorders are frequent. Visual and perceptual motor problems may cause difficulty with reading, spelling, writing and arithmetic. The amount and degree differs with each child from day to day. They may do excellent verbal work and thus pass from year to year. They may have difficulty in recalling, abstract thinking, problem solving, and organization of work. Rote memory is good in the young child, giving a false image of mental brightness.

Other characteristics the parents elaborate on are development and habit formations. Speech may be slow to develop with difficulty in articulation. Hearing may have mild impairment in discrimination. Toilet training may be late with enuresis until late school age. Tactile sensations may be impaired in the younger child so he seems insensitive to pain, reckless, and unheeding of danger. Eating habits are poor with peculiar tastes, and picky appetites. Sleep-

ing habits are poor. They fight sleep, are restless and light sleepers, sleep walk, have nightmares, as well as fear of sleeping. On the other hand, in some children sleep may be very deep with little movement.

A small percentage of children may be hypoactive, quiet, withdrawn, and frequently considered depressed, and autistic-like. They, however, fidget constantly, play with objects or just with fingers, squirm but do not disrupt or disturb others. They seek the corner of the room and entertain themselves, seeming to live in a world of their own. Schulman, et al [2] put actometers on both types of children and found the hypoactive had as much movement as the hyperactive. Hypoactive children may seem sweet, shy, over-willing to please, too friendly, pleading for constant acceptance, and want to be fondled. Feelings are easily hurt with frequent crying. Other symptoms are similar to those found in the hyperactive child.

Diagnosis

The history may indicate some or all of the various symptoms, or only subtle symptoms which are difficult to obtain from overprotective or guilt-ridden parents. Parents may put all the blame on an uncooperative school system at first, but with understanding, they can be drawn out to discuss preschool problems.

The physical examination is usually normal but may show some minimal abnormalities, such as, dental developmental defects or mild congenital malformations, such as, hypertelorism, extra digits, webbed digits, abnormally shaped heads, and misproportioned ears.

The neurological examination may be grossly normal but often shows the soft signs of poor coordination of finer movements or gross movements, or confusion in laterality with frequent mixed or crossed dominance. Eye abnormalities are frequent with strabismus, nystagmus or poor vision.

Psychological examinations are most important and should be obtained on all children suspected of being brain damaged. High verbal but low performance scores are frequent. Low scores may be obtained in abstraction, comprehension, visual-motor, or perceptual motor. The test may indicate dyslexia. Those tests most likely to pinpoint the problems are the Wechsler Intelligence Scale for Children, the Bender-Gestalt Motor Test, Goodenough Draw-A-Man Test, and, at times, reading tests.

The electroencephalogram should be obtained in all possible cases. Just as in the individual with epilepsy, 25% of interseizure electroencephalograms are normal, so many of these children may also have normal electroencephalograms. Electroencephalograms may be borderline, minimally abnormal or grossly abnormal, as seen in those of epileptic individuals. During sleep, 6 & 14/sec positive spikes are very prominent in many of these tracings. A normal electroencephalogram has no significance, but an abnormal tracing can be an aid in medical treatment.

Treatment

Treatment consists of three phases: the medical management, counseling, and educational planning.

Medical: Any complicating medical condition should be treated or a program outlining the treatment plan should be made. This should include proper eye glasses, speech therapy, hearing aid, medication to control seizures, exercises to improve coordination, etc.

The management of behavior with medication is becoming more important as we learn that patients are responding favorably to medication. The medications used can be divided into five groups.

I. Anticonvulsants, except for the barbiturates which make most of these children worse. The electroencephalogram is an aid in indicating which anticonvulsant to use. Patients whose electroencephalogram shows an irregular slow pattern or the paroxysmal high voltage slow pattern respond best to the hydantoins, such as, diphenylhydantoin sodium *(Dilantin),* mephenytoin *(Mesantoin),* and ethotoin *(Peganone).* These should be started in small doses and gradually increased to a point of control or toxicity, except with diphenylhydantoin which should be given according to the individual's weight

If the electroencephalogram has spike slow wave, phensuximide *(Diamox), (Milontin),* ethosuximide *(Zarontin),* acetaxolamide then methsuximide *(Celontin),* trimethadione *(Tridione),* or paramethadione *(Paradione)* should be used.

In 1968, for a six-month period all school-age patients with behavior disorders seen in the Clinic for the Exceptional Child were recorded. Table 1 shows the correlation of the electroencephalogram pattern with and without seizures.

Table 1: Electroencephalogram Patterns With and Without Seizures

	Behavior	Seizure and Behavior
Irregular or slow	**23**	**11**
High Voltage Slow	**4**	**4**
Spikes	**8**	**3**
Spike-Slow Wave	**4**	**4**
6-14/second positive spike	**10**	**0**
Normal	**8**	**3**

Out of a total of approximately 300 cases, 109 children were so markedly improved in behavior that they were able to return to school and remain in school, after having been on suspension, or about to be suspended, for behavior. Table 2 shows the distribution of 109 children's response to the anticonvulsants. Children with 6 & 14/second positive spike pattern in sleep electroencephalogram are the most difficult to control with any medication.

II. Stimulants such as dextroamphetamine *(Dexedrine)* or methylphenidate hydrochloride *(Ritalin).*

III. Antihistamines, especially diphenhydramine hydrochloride *(Benadryl).*

Table 2: Medications Effective in Behavior With or Without Seizures

	Behavior	Behavior and Seizures
Diphenylhydantoin sodium	**48**	**30**
Mephenytoin	**3**	**0**
Ethotoin	**5**	**1**
Methsuximide	**8**	**4**
Acetazolamide	**8**	**2**

IV. Tranquilizers—many of the present tranquilizers have been found effective: Chlordiazepoxide hydrochloride *(Librium),* thioridazine *(Mellaril),* meprobamate *(Equanil, Miltown),* ectylurea *(Levanil),* chlorpromazine *(Thorazine)* and an experimental compound, mesordazine.[3]

V. Carbonic anhydrase, mainly acetazolamide *(Diamox)* used in doses of two to three grams per day.

Often a combination of two or more medications is more effective than large doses of one. In our experience, effective combinations have been diphenylhydantoin sodium *(Dilantin)* and diphenhydramine hydrochloride *(Benadryl),* diphenylhydantoin sodium *(Dilantin),* and thioriadazine *(Mellaril)* or all three.

Patience on the part of both the parents and the physician is a requisite, since it may take some time to determine which medication or combination of medications will be effective.

Our experience and the literature indicates that these drugs have an ability to effect a broad range of functions and produce varied benefits. Bradley's early work reports the rotatory amphetamine improved scores on academic measures of arithmetic.[4] Other studies report increased attention span and ability to improve reading rate. An oversimple explanation of the drug effects might be that they make the child more amenable to a learning environment. If the child is more controlled in his activity level—able to sit still, able to attend to a topic longer—it stands to reason he will be a better student.

Counseling. In all cases there is an emotional problem. Both parents and child need counseling. The adolescent being seen for the first time frequently needs psychiatric type of care. It is my belief that counseling can be a very useful adjunct to the treatment program. The "theoretical" approach to the counseling may be as eclectic as the chemotherapeutic. The description of behaviors associated with this syndrome indicate that short attention, span distractibility, and perseveration are part of the usual therapeutic approaches limited in applicability, but some of the newer concepts have shown promise. Behavior modification therapy and family therapy are two approaches that have been beneficial. The goal directed, controlled aspects of behavior modification have been most helpful. These children have experienced great amounts of frustration in academic, social, physical, and athletic areas, and as a result, may evolve a defensive system that makes them "failure-avoiding," rather than "success-striving". In action, these children avoid or disrupt a task so that they don't have to face the prospect of failing it. The therapeutic approach is to organize the efforts of the child, family, teacher, and therapist into a series of projects or programs that will produce successes and modify behavior by teaching new responses. The family approach is stressed in treatment because these parents are routinely confused about how to handle these children—to punish or to bribe, to ignore or to praise—and they usually state, "We've tried everything." This is probably true; they have tried many things without a well conceived plan, without reasonable steps and a commitment to persevere. If this child has trouble learning in school, it is reasonable to assume that it will take repeated efforts to teach a behavioral response. Every failure—be it poor planning, inability to stick to the plan or an outright accident—reinforces the wrong response and will require time to extinguish before the right response is learned.

Education Planning. Recognition of the perceptual-visual motor handicapped child in the preschool years helps in planning an educational program geared to his needs. Even though medication may make him easier to live with and reduce the emotional overlay, the perceptual and visual motor problems are still present. Special educational programs are needed for many, while some may only need intensive remedial reading. Others will need a kinesthetic training program, of which there are several types. All of them aim at teaching by simultaneously using hearing, sounding or saying; feeling and making by tracing, printing or writing the letters of the alphabet and numbers. Other tasks involve learning to match objects, colors, and diagrams.

Physical exercise to improve coordination should not be overlooked. Gross and finer movements should be practiced, making a game of it. The exercises should slowly increase and become harder as he successfully accomplishes each task. He must gain the feeling of success so he can better compete with his peers. Such programs are already in operation and have had interesting results. In one study, it was noted that academic performance, as well as physical performance was improved.

REFERENCES

1. Clements, Sam D.: *Minimal Brain Dysfunction in Children,* US Department of Health, Education, & Welfare, 1966.
2. Schulman, et al: *Brain Damage and Behavior,* Illinois: Thomas, 1965.
3. Baldwin, R. W.; Kenny, T. J.; and Badie, D.: A New Drug for Behavior Problems in Children, *Cur Ther Res* Vol. 9, No. 9, Sept 1967.
4. Bradley, C.: Benzedrine and Dexedrine in the Treatment of Children's Behavior Disorders, *Ped* 5:24, 1950.



the *Adolescent* TURMOIL

GHISLAINE D. GODENNE, MD
Associate Professor of Psychiatry
The Johns Hopkins University School of Medicine



It is hard to put in writing an extemporaneous talk when so much of one's presentation involved examples from a long and busy practice with teen-agers. However, this paper will attempt to give an over all view of the subject of "adolescent turmoil." For sake of clarity, one should first define the limits of the adolescent period. Adolescence is a period of life ranging from puberty to adulthood. Although the age of puberty is relatively easy to determine, the one of adulthood is rather vague: one can set it at 18, 21 or 25, 45!—never! Arbitrarily, at The Johns Hopkins Hospital Adolescent Clinic, we have set the upper limit of adolescence to 21 years of age—the age at which an adolescent becomes legally independent from its parents. However, we exclude from our adolescent clinic young people who are married, who are financially and geographically independent from their parents, or who are in the armed service. This definition of adolescence has several corollaries. In this time of national prosperity, there are more adolescents since more young people can pursue studies and remain financially dependent on their parents. One can also understand how more of the older adolescents belong to the higher socioeconomic groups.

Having delimited the adolescent period, let's look at what makes it a period of turmoil. Adolescents go through many changes, both physical and psychological, which create inner tension and are sources of anxiety. If the tension becomes too great, the adolescent has difficulty tolerating it and tends to act it out, which explains the rather erratic behavior exhibited by so many teen-agers.

Physical changes are experienced with anxiety. The sudden growth, for instance, at the beginning of puberty requires from the adolescent a reworking of his body image. Also the simple fact that every teen-ager doesn't grow the same amount or at the same time results in marked difference of sizes among them, and causes the small or tall adolescent to feel odd. The apparition of the secondary sexual characteristics is another physical change which brings with it a considerable amount of inner feelings. In getting used to his new body configuration, the teen-ager compares his rate of change to the one of his peers. He suffers intensely if he matures very early or very late: Who of us hasn't run into a boy asking to be dismissed from gym, for instance? Such a request is often made by a teen-ager who feels that his genitals are smaller than those of his peers. He is afraid to be laughed at by his peers when, after gym, he can be observed while taking a shower. A girl who is late menstruating also experiences great concern about her future womanhood. In addition to these observable physical changes, it is felt that the hormonal rearrangement, which occurs in puberty, gives the adolescent a feeling of strangeness, of general malaise which could be at the basis of the increase in hypochondriacal complaints during adolescence.

While all this is occurring physically, the adolescent has to cope with additional, difficult, psychological problems. At the onset of puberty, the aggressive and sexual drives are markedly intensified. They have to be kept in check by an ego, which is already overwhelmed by the problems it has to solve. This often gives the teen-ager a fear of going crazy, going out of his mind, and in some instances, a weak ego can disintegrate and, thus, lead to a clear cut psychosis. In addition to the increase in drive energy, specific psychological issues have to be coped with in order to reach adulthood: The teen-ager has to move from a dependent position to an independent one. He himself must find the answer to the question, "Who am I?"

The shift from dependence to independence is a hard one, as both positions are very appealing. To give up what one has and loves (dependence) for something that one yearns for (independence) is a hard task, and this is the basis for so much of the adolescent's behavior. Billy's swing of mood for instance, so typical for a teen-ager, can be explained by a nonverbal communication between him and his mother. If Billy is good, obedient, and attentive, mother conveys to him the feeling that she hates to ever see him grow up and leave home. Billy reacts to this by being difficult, obnoxious, and loud. He wants and needs to grow up, but now he senses the maternal rejection, the wish of seeing the day come when he is on his own. Being frightened and unprepared to face the separation from home, he becomes once more the complacent little boy and the cycle starts anew. The "run away" adolescent is often one who has difficulty breaking his dependency ties, so he does it quickly in order to get it over with. The adolescent who rebels against any and all parental or adult limits is also an adolescent who is trying to establish his independence.

The second major task that needs to be worked through during adolescence is the identity issue. At the end of adolescence, the difficult question, "Who am I?" has to be answered. The various identifications made during adolescence have to be worked into one harmonious unit—"me." They have to be synthesized into a consolidated personality. They have to lose their tag of origin and become part of the young adult's personality. If the adolescent fails to do this, he will suffer what Eric Erikson calls an identity diffusion. The sexual identity crisis is a separate issue which is more marked for teen-age boys than for the adolescent girls. A girl can remain bisexual longer than a boy. She can be a tomboy and a sweet little party girl without awakening too much concern. A boy on the other hand has to be all boy, if not, he risks getting teased and berated by his peers. The boy who is not sure of his masculinity might want to act masculine to prove to himself and to the world that he is a man. This assertion of masculinity is seen, for instance, in the boy who fights continuously or the boy who becomes sexually promiscuous. The sexually promiscuous teen-age girl is motivated more often by her need to be loved and cared for, than by her need to prove her femininity.

For the teen-agers, the adults and children belong to a different world. The teen-ager, thus, needs to belong to a group of his peers. With his peers, he can feel understood and can share the miseries of the period he is going through. An adolescent who has no peer relationships should be a matter of concern.

For us adults who look at the struggling teen-ager, how can we best help him? We have to set few but firm limits. To avoid arbitrariness, the teen-ager should be involved in the setting of the limits and the sanction for their transgression should be discussed with him too. Limits should be set only in important matters. This will make authority more meaningful to him and reduce the opportunity for friction. Adults should be consistent and united in their decisions regarding teen-agers. They should listen to teen-agers and try to understand them.

In psychotherapy, the teen-ager should know that he is the patient. So, he should be seen before his parents and, preferably, before getting any information about him. His parents should be seen only by his therapist at the beginning of treatment in order to get additional history. The therapist should try at all times to remain the teen-ager's confidant without ever becoming his accomplice.

GRIEF AND DEPRESSION IN OLD PEOPLE



ROBERT D. PATTERSON, MD
Psychiatric Consultant
Section on Mental Health of the Aging
Division of Special Mental Health Programs
National Institute of Mental Health

Grief and depression occur to people at all times through their lives, but these conditions are special problems for old age. Much can be done to ease the pain of depression and help people complete their grieving.

Normal Grief

One of the frequent and difficult tasks of old age is grieving. It is a normal and necessary process which old people must go through more often than younger people, because they lose more loved ones through death.

A classic description of acute grief was written by psychiatrist Erich Lindenmann (1944)[1] who treated 101 patients experiencing acute grief, many of whom had lost family members in the famous Coconut Grove nightclub fire in Boston, in the early 1940's. A large number of the survivors, who were admitted to a general hospital, were simultaneously experiencing grief over the death of loved ones who had been with them at the nightclub. His description of their grief included somatic distress, preoccupation with the image of the deceased person, guilt, hostile reactions, and loss of usual patterns of conduct. The descriptions of cases which follow illustrate most of these normal reactions in grief. The somatic sensations he described were tightness in the throat, shortness of breath, an empty feeling in the abdomen, and weakness. The hostile reactions he described can be very puzzling and difficult for the physician, especially when his patient dies and the family's angry reaction is turned on him. It is comforting to know that such feelings have been described in healthy people during their grief after the Coconut Grove disaster. With that realization, the physician is less likely to become defensive about the family's accusations, and more likely to react helpfully to someone temporarily overwhelmed by grief.

An example of the loss of patterns of behavior is that of a man who, a few days after his wife's death, got up in the morning and wandered aimlessly around the house, unable to carry on his usual routine because his wife was gone. Without her, his old pattern of putting on coffee for them to drink while she fixed breakfast became meaningless.

Grieving is the gradual process of destroying the intense emotional ties to the dead person. The best example of this process is the intense, sad feeling provoked by thinking of the dead person. Each time this happens, it gets the sad person a little closer to being able to think about the dead person without being overwhelmed by feeling. The funeral and visits by friends to the person in mourning provoke sad memories and, thus, help in the process of grieving while giving support to the sad person. However, the process of grieving—sometimes called the grief-work—goes on for months after the loss. After her husband's death, a widow may go through his clothes and belongings in preparation for giving them away. Here, too, she is doing her work of grieving. Many of the pieces of clothing she looks at will stimulate an intense image of her deceased husband and feelings about his death.

Restitution

Breaking down the intense emotional ties to the deceased is only one part of grieving, however. The other part is making restitution for the loss. Sometimes the loss can be partly made up by a new spouse or friend or renewed closeness to a child. Other kinds of restitution are also needed. For example, a widow who had regularly gone out with her husband and another couple was never invited out by them after her husband died. She had to realize that the other couple really only liked her husband, and so they were not interested in her any more after he died. She had to struggle with this painful realization and develop new friendships of her own. A person who does not accomplish grieving will remain sad and withdrawn and can be appropriately diagnosed as depressed.

There are specific things that can be done to help patients who are grieving. By encouraging them to talk with you and others about their loss you can discover how the patient is handling grief. If she seems not to understand the need for grief-work, a comment that thinking and talking about her dead husband is a necessary part of recovering from the shock of his death, and your sympathetic recognition of what hard work this is, may enable her to think about it and to continue grief-work with others after she leaves you.

Sometimes family members try to "protect" someone from doing their grief-work by not mentioning the dead person. They may need our help to realize that they can really help by talking sympathetically with the sad person about what it feels like to be grieving.

There is a natural tendency for people to avoid those who are bereaved or depressed. The same tendency operating in us makes it hard work to talk with such patients. A psychiatrist may find himself getting very interested in hearing more about the old lady's Oedipus complex at age five, or a general practitioner may become concerned about the complexities of her PBI. We must each be cautious that we are not avoiding the hard work of helping the patient cope with sad feelings.

If grief-work could be accomplished in more people much chronic unhappiness could be reduced. It is common to see people who still get tearful at mention of a lost person years after the death. This represents still unfinished grief-work. It is fortunate that in such cases of unfinished grief-work even years after the loss, discussions about the relationship to the lost person can lead to a successful completion of the grief-work.

Old people more often than young people have experienced the death of their parents and, in the process, have learned something about grief-work. Asking how they accomplished mourning these losses may remind them of resources to use again and may bolster their confidence through recognition that what they must do now is something they have already done earlier.

Depression

Sometimes the breaking down of emotional ties to the lost person and restitution for the loss is not accomplished; in that case there is depression. Although there are many causes for depression in old age, feelings of hopelessness and helplessness are the essential features of all depressions. While it seems as though this should be easy to spot, depression can be surprisingly hard to identify. There are several reasons why it may be overlooked. First, the patient comes to talk about some physical illness and the subject of feelings just does not come up. (Hypochondriacal symptoms can be a tip-off to look for depression.) A second reason depression may be overlooked is that the patient, even when asked, may not realize that he is depressed or he may not be able to admit that he is feeling depressed. He may not know what to call his unpleasant feeling or be trying to use an "ignore it and it will go away" approach.

A third reason depression may be hard to identify is that sadness, apathy, and quietness may be mistaken for senile changes. In medical school we were taught the aphorism "All that wheezes is not asthma." We might coin one for geriatric psychiatry to the effect that "All of the problems of old people are not chronic brain syndrome." The distinction between organic impairment and depression is important because depression requires special treatment. If it is not differentiated from organic changes, it will go untreated. The patient may have both organic deficit and depression, but the presence of organic deterioration should not discourage the attempt to find the cause of the depression and treat it.

When a patient is suspected of having organic deterioration, the examiner must force himself to become rigorous and to list just what signs suggest organic mental change. For example:

Did he say his memory is failing or that he cannot think as clearly or as fast as he used to?

Did his memory fail in specific instances?

Was his thinking less clear and less quick than would be expected for a person with his experience?

Did he fail to understand instructions?

Did his mood change quickly and unpredictably? For example, did he cry without feeling sad?

Each of these points *can* be good evidence for organic deterioration. If the patient has some of these signs, an organic brain syndrome may be present. Then a differentiation from depression must be made. Some points to consider are the following:

Did he think he was depressed and did he seem sad when he talked?

Did he have a sense of helplessness and hopelessness?

Did he insist that he is ill or deficient or defective without evidence?

Was there a current cause for him to be depressed?

Was he slowed up in all of his mental and physical functions as a result of the depression? This slowing up might, at first, be mistaken as evidence for organic deterioration.

If there is clear evidence of failing mental function and no depressive symptoms or other major emotionally upsetting situations which would account for it, an organic brain syndrome is likely.

In agitated depression, the sadness and sense of hopelessness and helplessness are present along with tension, agitation, insomnia, and feelings of worthlessness.

Depression may be the most prominent symptom in some physical diseases, and so identification of depression may indicate the need for physical diagnostic tests. Cerebral ischemia, an otherwise silent brain tumor, endocrine imbalance, or vitamin deficiency, such as in pernicious anemia, may be causes of depression which should be ruled out.

If a history is taken carefully enough, the cause of depressive feelings can almost always be discovered. Often family members can be invaluable in establishing the onset of depression and suggesting what the cause is. We must suspect that we don't know enough if our formulation of why the person is depressed is still fuzzy.

An example comes to mind from a longitudinal study that I have participated in involving normal aged men. I reviewed interviews made several years ago. In one interview, the subject was depressed but I could not satisfy myself that I knew why. I thought about the fact that he had recently retired and might feel a loss of status by not having a job anymore or that he felt he had not been much of a success in life and now his chances for success at work seemed to be over. But none of these seemed to be the specific cause. From talking with another person who knew the man at the time of the interview, I learned that he was worried about a possible carcinoma of the prostate for which he was being treated. I looked again at the interview and then could see that he had mentioned this treatment and that he knew it was sometimes used for carcinoma but he denied that he was afraid of having cancer. His depression was treated incidentally when the study team recommended a biopsy of a nodule in his prostate which turned out to be benign. It became clear that he was depressed because he suspected

he had a fatal illness. This incident emphasized that persistence in looking for a convincing reason for depression will be rewarding in most cases.

Common Causes of Depression

Causes of depression are innumerable, but only a few kinds of problems are the cause of a large number of depressions. Among the most common causes of depression is loss of an important person, usually through death, but sometimes through children moving away or estrangement. Treatment may focus on completing the grief-work, of accepting living without the loved one and finding new people and new interests or reconciling the estranged people.

Not all losses are losses of people; they may be losses of things or hopes. An example is depression precipitated in an old person by his having to move because of urban renewal from a home after having lived there for many years. Depression associated with relocations of old people is only part of a complex phenomenon, which leads to increased mortality when old people are moved. It appears that preparing the person emotionally for the move can reduce the incidence of death following moves. An example of a feeling of loss because something expected did not come about is that of a man who hoped to live in retirement on income from the sale of his business, but the person to whom he sold it closed the store and could not keep up the payments.

Retirement is a usual cause of turmoil in the lives of old people and it frequently causes depression. Sometimes retirement represents closing the door on hopes for achievement which have not come about. Forced retirement may make the person feel suddenly old and useless. Helping the person put problems like this into words—perhaps through suggesting possible explanations if he cannot find reasons by himself—may start a process of thinking in the patient which he can carry on at home to his great benefit.

Physical illnesses often lead to depression. Misconceptions about an illness can be very easy to clear up if recognized. For example, a very passive man had the idea he was going to become blind from an inherited eye defect. He did not seek any follow-up from his doctor, but made plans for the time when he would be blind—including taking a job in a darkroom where a blind person could function as well as a seeing person. He came for psychiatric help because he felt chronically depressed and apathetic. His expectation of going blind seemed, to him, just another fact in his life—he did not realize the tremendous importance of this idea on himself. Treatment consisted of referring him to an ophthalmologist who said there was no reason for him to expect blindness. He needed no other psychiatric treatment.

Real illnesses that lead to debilitation and death are more difficult to cope with. Patients have highly personal reasons for being depressed when they are physically ill. One patient's fantasies may be worse than what is reasonably expected, and he can get great relief from discussing them. Another man may be depressed because cancer makes him dependent on his wife, while feeling independent was something in which he always took great pride. A woman may be ready to accept her own death, but depressed at the prospect of her chronically ill husband having to live without her. Still another patient may be depressed because he feels he will break down when his illness becomes painful, so that he will disgrace himself. Many of these problems do not have very satisfying answers, but exploring the causes of the feelings can in itself be a great relief to the patient and may get him started to work finding solutions.

Treatment

A Case Example: Almost all psychiatric symptoms in old people will be helped by talking—talking with the patient or sometimes with the family. Sometimes medications are useful, but they are often of secondary importance.

A 66-year-old man was treated with talk and drugs when he developed an agitated depression. He had always been single, eccentric, isolated, and had no family close enough to him to be of help in a crisis. When first seen he had not been to work for two weeks. He worked as an overhead crane operator in a large welding shop. He said he could not work because he could not see clearly. A physical examination showed no cause to explain his symptoms. He was very tense, fidgety, had jerky movements of his upper body, and winced frequently. He was not inclined to talk about feelings or be introspective, but between his descriptions of his eyes and other somatic complaints, he made it clear that he was very depressed and hopeless about his situation. Being unable to work was making him panicky about his future. Unfortunately, it was never possible to get the type of clear understanding of the cause of his depression which is recommended. Two medications were prescribed within a few days—a tranquilizer and an antidepressant. As he started the medications he was seen twice weekly for about 10 to 15 minutes. He liked to talk longer, but it would not have been helpful, and while he was an interesting and likeable person, it would have been easy for the psychiatrist to get too much of his repetitive talk and become angry with him which would have been very detrimental to the developing relationship. He protested that the medications were no help, but he was urged to keep taking them as it might take several weeks to get a good effect. He openly doubted this was going to succeed but kept his appointments and took his pills. By the end of four weeks, his dose of antidepressant had been increased to the maximum recommended with still no effect. An important point

is that the dose was gradually increased to the maximum recommended and maintained for the three weeks that the slower acting antidepressants sometimes require. It probably was possible to keep him in treatment through this long wait for results because he was seen twice a week and listened to sympathetically when he talked about his somatic complaints. The next week he began to feel better. He felt energetic and optimistic. He quickly went back to work. It was thrilling to hear him describe how the men in his plant applauded as he started to climb to the cab of his crane the first time he was back. (One reason they liked him so much was that he always brought about 30 candy bars with him which he threw down to the men working below him for them to eat.)

The success of this therapy depended upon the relationship fostered with the patient in which understanding of his plight was demonstrated, particularly by seeing him often, even though not for long visits. Besides providing a sympathetic ear, it was undoubtedly this demonstration of concern that persuaded him to keep taking the medication until it became effective.

Utilizing Community Facilities

The patient described required a modest amount of a doctor's time to treat, but there are patients who require large amounts of time. Here community facilities, where they are available, can sometimes be used. Many of you practice in areas where clinics and social service agencies may not exist at all. Community mental health centers within a few years may make such services available. However, it is impressive that people over 65 make up 19% of all admissions to State and county mental hospitals, and yet they make up only 2% of all patients admitted to psychiatric outpatient clinics. This suggests that especially for older people, greater use of community facilities of many types—not just psychiatric outpatient clinics—could reduce the number of old people who reach crises that require hospitalization.

Increasing our utilization of golden age clubs, friendly visitors groups, family service agencies, or homemaker services, etc., may involve defining our role as doctors a bit differently from the way we have in the past. By making frequent use of such resources, we include in our definition of our role, for example, helping a widow adjust to her husband's death through directing her to community resources.

Among the facilities are family service agencies in several areas of Maryland which offer services of social workers who can counsel on emotional problems. For example, suppose an old woman who lives with her daughter and son-in-law is deteriorating physically or mentally and apparently will need institutionalization, but she wants to continue to live with her daughter. The daughter sees the strain placed on her marriage by the great demands her mother makes, but she cannot bear to see her mother sent to an institution. Helping the mother and daughter understand what is going on and what should be done will likely take a lot of talking. A family service agency social worker can be of great help with this kind of case.

Visiting nurses and public health nurses can be called on to help with some psychological problems.

Do you have old patients who could benefit from frequent regular phone calls from someone who will check to see that the patient is all right, at the same time providing a friendly link to the world outside? Such a service is available through several of the County Commissions on aging in Maryland. Washington County has a Friendly Visitor Service, and Montgomery County is about to start one. Ten senior citizen centers are operating in the State, as well as many Golden Age and similar clubs.

When you are lucky enough to have a new community facility in your area, you then need to find the proper place for that asset in treatment plans so that when the patient comes in you will automatically think of the facility that can benefit him. Referring patients to such facilities and seeing what results you get will be the best guide. Your participation in the formation and direction of local facilities can be of great benefit through helping others be more aware of what the needs are from your point of view.

Many old people are not getting the community agency help they need. Some reach a crisis and must go to total care institutions. There are not enough community-based helping agencies, but probably we can use the ones we have more than we do now.

Summary

Normal behavior in acute grief includes somatic distress, preoccupation with the deceased person, guilt, hostile reactions, and loss of usual patterns of conduct. Ways of helping people accomplish grief-work and restitution for their losses are discussed. Depression may be a diagnostic problem because it is easily overlooked in the old patient or mistaken for organic mental decline. The importance of finding the cause of depression is emphasized and treatment techniques are discussed. Greater use of a wide range of community facilities for help with emotional problems of old age is urged.

REFERENCE

1. Lindemann, Erich: Symptomatology and Management of Acute Grief, *Am J Psychiat*, **101**:141-148, 1944.

The author wishes to acknowledge the generous help of Dr. Robert Butler, Consultant to the National Institute of Mental Health; Research Psychiatrist and Gerontologist, Washington School of Psychiatry, Washington, D.C., in preparation of this paper.

SOME MEDICAL AND SOCIOLOGICA

The major health problems of our cities are essentially the health problems of the poor. The cities contain a large percentage of the rich, but they also contain 54% of the poor. Many of the latter are black, and although the majority of the poor in America are white, the nonwhite are twice as likely to be poor as the white.

M. ALFRED HAYNES, MD
Project Director
National Medical Association Foundation

Many of the large cities show what has now become a fairly monotonous trend. In the center of the city is the poor, black community, usually living in dilapidated row houses surrounded by uncollected garbage, or imprisoned in housing projects which could stifle any spark of human dignity. This core is surrounded by a white, much wider circle of middle income people living in detached houses or high-rise modern apartment buildings, often surrounded by beautiful lawns. On the suburban periphery, there is an almost lily-white circle of higher income people who retreat into beautiful, modern homes surrounded by neatly trimmed lawns. A visitor from outer space, where everyone is supposedly green, would find this to be a very unimaginative illustration of our modern art.

Poverty and social injustice have combined to create the most scandalous and shocking health conditions in our cities, in this richest and greatest country in the world. Some of these problems are evident in the vital statistics of our cities. In Washington, D. C., there are more than 2,000 excess deaths in the black population each year. This excess is computed by assuming that the age-sex-specific death rates of the white population for the year 1966 had applied to the nonwhite population.[2] In this case, the actual number of deaths exceeded the expected number by 70%. In the city of Baltimore the observed number of deaths exceeded the expected number by 50% during the same year. In 1960, the excess in Baltimore was 40%, indicating that the situation has actually deteriorated in recent years.

The differential between white and nonwhite does not tell the whole story. For example, in Washington, D. C. there is a wide economic spread in the black population. If the health status of the poor, black population were compared with that of the middle income, white population of the city, the differential would be even greater.

The specific causes of death which contribute to the wide differential include such conditions as, the diseases of early infancy, accidents, pneumonia, cardiovascular diseases, cirrhosis, diabetes, and homicide. Clearly, many of these conditions can be prevented by the application of medical knowledge which is currently available. Others, such as homicide, are less amenable to the usual medical approach, and progress may depend upon a substantial change in the social environment of our cities. To the extent that the deaths are due to conditions which are rectifiable by either medical or social means, they can all be considered social homicide and the burden rests upon our entire society.

Deaths are the clearly observable and easily defined tip of the iceberg. But for every death by accident, there may be 100 cases of illness or disability. For every death by cirrhosis there must be numerous cases of alcoholism, which represent a great economic and social burden. Tuberculosis has not yet been eradicated and venereal disease is on the increase.

With all of these problems, the inner-city residents find it difficult to obtain health care. The doctors, like the churches, are leaving the inner city. Hospitals do likewise. The transportation system is in conspiracy with the health care non-system to de-

In general, the poor have 5 times as many heart conditions,
6 times as much arthritis and rheumatism,
6 times as much high blood pressure,
and 8 times as many visual impairments.[1]
It is unfortunate to be poor,
but to be poor and black is to carry a tremendous burden
of increased morbidity and mortality.
This is the group which forms the heart of our cities.

prive the mid-city residents of access to health care. In Watts, there is a common saying that the transportation runs east and west while the jobs run north and south. In some cases, the indigent or the medically indigent must travel across the entire city, bypassing several private hospitals in order to be treated at the city hospital. In practice, unlike in theory, freedom of choice does not usually extend to the poor. Occasionally, one section of a city must riot before it can get a hospital. Another city must riot before it can persuade a medical school from expanding in such a way that it deprives the poor of housing. The only real freedom which the poor seem to have is the freedom to destroy.

Many of the problems are essentially due to our own failure to understand each other. The health economist talks about the billions which the government spends for health care. This means nothing to the mid-city residents who consider what they get as not worth a dime. The university treats the patient as "interesting clinical material" when the patient wants to be treated as a human being. The health department is more interested in disease and the prevention of disease than it is in people. As a result, there are a multiplicity of categorical clinics, but very few centers for comprehensive care. We are so closely wedded to the concept of charity medicine that we cannot appreciate the fact that some people do not want charity.

This assessment is not intended to ignore the many attempts which have been made to solve some of the problems. The results sometimes appear to be inversely proportional to the efforts, and the efforts have been many. The Office of Economic Opportunity has developed neighborhood health centers where the poor can obtain comprehensive health care of a high quality. Although the services are offered to a small segment of the population in need, this segment, usually referred to as the "target population," could receive some of the best care available anywhere in America. The kind of care offered under these circumstances could almost encourage belief in the common myth that the poor receive better care than the middle-class. There are two problems, however. The demands for personnel for these programs have been so great that, if they were met for the target population, this itself would accentuate the crisis for the rest of the poor. In an attempt to provide high quality health care for a few, we cannot deprive the many of the little which they would otherwise receive. This situation could be partly alleviated by an imaginative use of nonprofessional personnel which could, in turn, benefit all. The second problem is equally serious. Health care, which is segregated to the poor, will carry the stigma of inferior care, regardless of the quality offered. The black poor have had many years of unpleasant experiences under the doctrine of separate but equal. They have, therefore, learned to be suspicious. The provision of comprehensive care for the poor under a separate system is better, as a short term objective, than no care at all. But, as a long term objective, Americans can hardly be satisfied with anything less than a single system of health care with equal access to all.

The Medicaid program has the potential for re-

moving the economic barriers for the poor, and permitting access to a single system of care—but this is so only in theory. Some physicians cooperate but many do not. The reason why some do not cooperate is because some states are committed to preserving the two class system. The fees for Medicaid patients are fixed substantially lower than those received from private patients. In Maryland, the fee paid to the private physician for an office visit is less than half of that which is paid to the hospital on an out-patient basis. This can hardly be considered fair, either to the patient or the physician. Even at this rate, a few physicians have been able to do well financially through the program because a large proportion of their patients fall into the Medicaid category. Those physicians who perform this service should not be penalized as long as they are providing adequate care. There are some physicians who are unwilling to serve Medicaid patients at any fee. These are the ones who deserve our criticism. Another group who deserve our censure are those who willfully exploit the system. These physicians do us and the patients a disservice, but it should be remembered that this group represents not more than 1% or 2% of the physicians serving Medicaid patients.

The hospitals are now carrying a disproportionate share of the burden of providing primary care. This is unfortunate, not merely because it is provided at higher cost, but because hospitals are not the proper place for providing most primary care. Poor patients, like everyone else, deserve the personal care of a physician, and institutional care is a poor substitute. There are no compassionate institutions. Most primary care offered by the hospital clinics should be considered an improper use of the hospital, and at best a necessary evil. The trend towards hospital centered care may seem desirable from the point of view of the administrator, but from the point of view of the patient, the center for care should be the personal physician's office. Ideally, health care is a very personal matter. Purchasing health care is not the same as going to the supermarket. Many of the problems which have arisen in our cities, have occurred because the poor realize that so often they must deal with people who do not really care. The general practitioner has traditionally been respected by our society because *he* does care.

Obviously, there is no simple single solution to these rather complex problems. A pluralistic approach is most likely to yield best results, at least for the present. In this case, the private physician will continue to play an important role, either in solo practice or in groups. Although group practice seems to offer many advantages for both physician and patient, there is still room for the solo practitioner, and he is likely to be with us for some time. Better results can be achieved if the traditional type of group practice, consisting primarily of clinicians, were combined with the best preventive aspects of the neighborhood health center. In this way, one could remove the barriers between private and governmental medicine, and provide services in a single system of care. A fair amount of suspicion on both sides still prevents us from achieving this goal.

The poor of our urban communities have had a dream—a dream which our government and our Constitution may well have inspired. They dream that someday they will have one nation indivisible, and this applies also to health care. It is not pleasant to consider what will happen in our cities if that dream is not realized. Langston Hughes raised the question in these words:

"What happens to a dream deferred?
Does it dry up like a raisin in the sun?
Or fester like a sore—and then run?
Does it stink like rotten meat?
Or crust and sugar over—like a syrupy sweet?
Maybe it just sags like a heavy load.
Or does it explode?"

The general practitioner can in his own way do a great deal to prevent this dream from exploding.

REFERENCES

1. US Department of Health, Education and Welfare, Medical Care, Health Status and Family Income, *US, National Center for Health Statistics Series* 10, No 9, p 60, US Government Printing Office: Washington, DC, 1964.
2. District of Columbia Department of Public Health, *Vital Statistics Summary*, 1966.

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee of the Faculty met on July 24, 1969, and took the following actions:

1. Authorized redrafting of current policies in respect to laboratory referral services.
2. Authorized legal counsel to appear as *amicus curiae* in a Court of Appeals case in connection with acceptance of testimony of a chiropractor as a "medical expert."
3. Was informed that there were no legal restrictions in connection with development of legislation or regulations that would prohibit all unethical practices by all laboratories.
4. Adopted the following statement to be distributed to chiefs of staff at all general hospitals in Maryland:

   When services at a hospital in Maryland are temporarily suspended because of conditions beyond the control of that institution, thus necessitating the transfer of the patients to another hospital for their medical care, it is recommended that hospital staffs adopt the general policy that all physicians who have privileges at the hospital that is forced to temporarily cease operations be automatically granted courtesy privileges at the hospital to which their patients are transferred or admitted; with the understanding that such courtesy privileges would be granted on the same basis and conditions under which they were granted at the closed hospital.
5. Referred the following matters to the Faculty's Liaison Committee for consideration and report to the Executive Committee: use of a recorded telephone device by physicians referring patients to hospital emergency rooms, and the question raised by the General Assembly regarding physicians making house calls.
6. Submitted various names to the AMA Board of Trustees for consideration for appointment to various AMA Councils and Committees.
7. Agreed to ask the Deans of Maryland's two medical schools for suggestions of names for submission to the US Pharmacopeial Convention Nominating Committee for its consideration. The individuals could be elected to the 1970-1980 Committee of Revision.
8. Approved appointment of the following individuals to the Medical Advisory Board of the Department of Motor Vehicles:

   Maxwell N. Weisman, MD, Psychiatrist
   Katharine V. Kemp, MD, PM&R.
9. Designated **Katherine H. Borkovich, MD,** to act as Faculty representative to an AMA conference on "Utilization Review by Peer Mechanism," scheduled for Saturday, November 29, 1969, in Denver, Colorado. The Faculty will pay expenses in this regard.
10. Designated **Robert J. Wilder, MD,** as Faculty representative to serve on the Emergency Care Advisory Council of the State Health Department.
11. Agreed to recommend to the House of Delegates honorary membership in the Faculty for **William Kouwenhoven, PhD,** who was recently granted an Honorary MD degree by The Johns Hopkins University School of Medicine.
12. Authorized a contribution to the Maryland Medical Political Action Committee for educational purposes.
13. Heard a summary of the activities of the Columbia Hospital and Medical Foundation in Columbia, Md., by **Harvey Minchew, MD,** and **Harvey Katz, MD.**
14. Heard and referred to the Policy and Planning Committee a suggestion from **William J. Peeples, MD,** that the faculty sponsor and approve a proposal for medical care to Maryland residents involving a "medical district" concept.
15. Accepted a report of the Ad Hoc Committee on Admission of Patients to Coronary and Intensive Care Units, which is repeated verbatim at the end of this report.

16. Discussed and concluded that no further action is needed in connection with a question raised regarding Blue Shield's handling of a fee dispute between a nonparticipating physician and a federal employee.
17. Received the second working draft of the JCAH Standards and learned that suggestions of the Maryland physicians who attended this working session in Chicago were incorporated into this second draft.
18. Endorsed the idea that the Faculty should employ a consultant, well versed in economic matters and capable of compiling statistical meaningful information on cost of living, physicians' fee increases, and other data.
19. Agreed to ask the two medical schools in Maryland to again consider the question of including courses on socioeconomics of health care in the curriculum.
20. Heard that the Social Security Administration at Woodlawn had requested and received the names of 33 physicians who had received more than $25,000 in one year under the Medicare Program.
21. Declined to make a financial contribution to the Man-Alive Program, in line with Faculty policy regarding such contributions.
22. Authorized appointment of a special group to prepare a charter or bylaws for the formation of a nonprofit corporation to develop the Hearing and Vision Screening Survey Program.

Report of Ad Hoc Committee on Admission of Patients to Intensive and Coronary Care Units

In this age of subspecialization, more and more hospitals are utilizing special care facilities. It is recognized that individual hospitals may have various specialty units and may have different problems, or approach the same problem in different ways. It is the desire of this committee to recommend general principles rather than restrictive, specific edicts. For example, a mechanism for determining admissions and discharges should be set up in each Special Care Unit (CCU, ICU, etc.). In this broad context, the following guidelines are suggested:

Special Care Units

CORONARY CARE UNITS

1. A CCU should be supervised by someone with special training or interest in cardiology.
2. Each hospital medical staff should establish its own criteria for CCU privileges. These criteria may include:
   (a) training and experience
   (b) special courses or instruction
   (c) availability
3. If an attending physician meets qualifications for CCU privileges, he may treat patients himself, or elect to transfer them to someone else with CCU privileges.
4. Admission of a patient to a CCU implies agreement by an attending physician that standard treatment may be employed, but medication or treatment varies as emergency circumstances dictate.
5. This committee, in principle, is opposed to a physician meeting qualifications for CCU privileges, being compelled to transfer his patient to another physician with CCU privileges.

INTENSIVE CARE UNITS

1. It is recognized that ICU patient population may embrace multiple specialties and no one physician could logically be expected to supervise the specialized care of every ICU patient. An ICU may be supervised by a director or by a committee or both. In either event, this direction would be mainly in an administrative capacity, as well as being available for emergency situations.
2. Hospital medical staff may elect to establish special criteria for ICU consulting or admitting privileges.
3. Admission of a patient to an ICU implies agreement by an attending physician that treatment or medication may be as varied as emergency circumstances dictate.



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Rehabilitation of Patients Suffering from Fracture of the Hip*

Part III:

Treatment by Prosthetic Replacement of the Femoral Head

JOHN D. HSU, MD
Div. Orthopaedic Surg., Dept. Surg.
Baltimore City Hospitals and
Johns Hopkins Medical Institutions

The introduction of the prostheses for the replacement of the femoral head has been a major development in the treatment of the subcapital fracture of the hip. Only in the past two decades has success been achieved with this method. R. and J. Judet developed and used the acrylic, plastic "stem" type prosthesis. They demonstrated that replacement of the femoral head with an artificial one for certain problems of the hip was not only possible, but gave beneficial results.[1] Moore, independently, using structural and engineering principles, developed the "medullary" type of prosthesis. It was made of an inert material, Vitallium, which has been shown to be well tolerated by the tissues.[2]

* *Supported in part by an American Geriatrics Society Award and USPHS Grant No. 5T1 GM00624-08.*

With such developmental successes, the use of the hip prostheses then became widespread and was no longer used for experimental or heroic measures, such as the need for replacement of the femoral head for massive bone loss.[3] With careful analysis of the results over the past 20 years, the prosthesis has become a well accepted and powerful tool in the armamentarium of the orthopaedic surgeon.[4-6] Modifications and developments have produced variations of the two basic types, many of these are in use today. The change from acrylic to metal has guaranteed their indestructibility.

In the cases that we are interested in, eg, in fresh fracture of the hip where the prosthetic replacement of the femoral head was the treatment of choice, their use has mainly been in the elderly patient.[7] Because of its use, our thoughts on the prognosis and rehabilitation methods of the fractured hip in the aged has changed dramatically. The long period of suffering at bed rest with pain, complications and factors leading to both physical and mental decompensation, social and rehabilitative placement problems, as well as the non-union of the fracture site, has greatly diminished with better preservation of life. For this reason, 1950-1960 has frequently been referred to as the "decade of the hip prosthesis." [8]

Selection of Patients Under Our Study

Patients so treated at the Baltimore City Hospitals between 1963-1968 who met our criteria for the use of the previously described Evaluation Tests were used in this study.[7] The prostheses used in the majority of cases was the Moore Prosthesis. Included in our series are patients with fresh subcapital fractures. They must have ambulated just prior to the accident and operation, and be without terminal illnesses or other serious medical complications. Operative indications and the operative technic in each case follow well-described principles and guidelines.

Rehabilitation

These patients are in the older age group. Even in the absence of other complicating illnesses, the management of fractures in the elderly patient is decidedly different from the care of the younger patient.[9]

The injury itself may precipitate decompensation of the fragile physiological balance of an elderly patient. Metabolic, psychological, and dietary deficiencies may become manifest, and when they do, they may occur together to compound the problem. In all cases, however, the surgical trauma inflicted by the insertion of the Moore Prosthesis is a major one, despite the surgical skills of the operator. It is a major undertaking with an average loss of two units (1000 cc) of blood. The postoperative regimen requires more careful general medical and nursing care, blood and fluid replacement, as well as careful observation for confusion and bizarre behavior that may cause harm to the patient.

The initiation of the rehabilitation regimen can only be made when the recovery progress is satisfactory. An initial delay is almost always encountered before evaluation can begin. During this interval, measures to allow for preservation of the patient's physical activities, such as upper extremity and chest exercises, are needed and should be started as soon as possible, postoperatively.

Because of the nature of the prosthetic device, the physical therapy program may be modified from that of the program for patients suffering hip fracture treated by hip pinning. After sufficient confidence is gained by the patient and gradual readjustment made to the standing position, ambulation on the affected limb is possible without causing harm to the injured member. This is a great asset, especially in patients who are pain free and are willing to cooperate but tend to sometimes become confused in the strange surroundings or have trouble with balance. Aids, such as parallel bars and walkers, are most important at the early training phase.

Independence from the hospital and cumbersome aids is the ultimate goal and this depends on the individual. However, some form of a walking aid, eg, a cane should be used despite satisfactory progress.

Results

In our survey, 44 patients so treated met our criteria for study. The period of follow-up was from six months to two years with periodic re-evaluations. All except two patients were in the Group III age group, two were 61 years of age.

Initial mean MSCL score was between 26-30 (maximum possible score is 50) and initial mean ADL score was 30 (maximal possible score is 100). Again, one should take into account the postoperative status of the patient and the ADL score adjusts itself in the final evaluation, as the patients become ambulatory. The final ADL score was between 71 to 80 for this group.

Fifty-five percent of the patients were able to ambulate in some form. A large majority of these patients needed an aid such as a walker, crutch, or cane to help with balance; 28% required a wheelchair as their sole mode of getting about, and 14% attained the maximum activity possible by being able to sit up in a chair.

Summary

Patients with Austin Moore Prosthesis replacement of the femoral head for fresh subcapital fractures have a slightly easier time in the convalescent and rehabilitation period because they can bear some weight on the affected leg without causing damage or changing the prognosis. A comparison with the

results of the elderly patients treated with hip-pinning, previously reported,[10] is not attempted because of the large individual variation possible, but one can see that the initial MSCL and ADL scores do not show much difference, reflecting the dependence on age as to the ability of an individual's performance.

The time taken for an elderly patient with a prosthetic replacement of the hip to become steady when upright can be considerable and is certainly comparable to the time taken by a similar elderly patient with hip nailing. Thus, early weight-bearing in most cases of prosthetic replacement does not shorten training time in the more elderly and confused patient, but allows a slightly more liberal regimen with less emphasis on the problem of non-weight bearing on the affected leg. Because of this, in discharge planning, it may be possible to recommend less skilled family or custodial care, which sometimes means the difference between discharge from the hospital to the family and the need for chronic care facilities. Also, the need for a walking aid, the continuation of active care, and the dependence upon the treating institution, especially the Department of Physical Therapy is a common factor to all elderly patients with fracture of the hip, whether treated by hip pinning or prosthetic replacement of the femoral head.

Part IV: Treatment by Non-Surgical Methods

Nonoperative treatment for fracture of the hip continues to be an accepted method, despite the development of operative skills, methods, and materials, as well as the orthopaedist's training and enthusiasm for the operative treatment. Although not the ideal means for use in all types of hip fractures and in all persons, there are occasions when such treatment is indicated.[11, 12]

Many methods are available. Depending on the site and stability of the fracture, the methods may include immobilization by bed rest alone, bed rest with skin or skeletal traction, or in a plaster cast.

In all cases treated by this method, there is dependence on bed rest and bed care in the early period, followed by a training period to help the patient become as independent as possible using various supports and aids. During the period at rest, chest and upper extremity exercises are important. They keep the patient occupied, and good ventilation is assured. Strengthening of the upper extremity muscles is very important, especially for the later training period for transferring and using the various supports and aids.

Because of the slower nature of the regimen, more patience regarding the psychological needs must be realized. The inactivity of a previously healthy, normally functioning person may lead to many anxieties. Thus, an active occupational therapy program should be presented early.

As the patient's fracture heals and becomes stronger, a progressive training program in ambulation may then be structured with an evaluation of his abilities. With good cooperation, usually, at this stage, the regimen does not become much different than that of the rehabilitation of a person with fracture of the hip treated by operative methods.

REFERENCES

1. Judet, J. and Judet, R.: The Use of an Artificial Femoral Head for Arthroplasty of the Hip Joint, *JB&JtS* **32B:** 166, 1950.
2. Moore, A. T.: *Hip Joint Surgery: An Outline of Progress Made in the Past Forty Years,* Columbia: A. T. Moore, 1963.
3. Moore, A. T. and Bohlman, H. R.: Metal Hip Joint: A Case Report, *JB&JtS* **25:** 688, 1943.
4. Hinchey, J. J. and Day, P. L.: Primary Prosthetic Replacement in Fresh Femoral-Neck Fractures, *JB&JtS* **46A:** 222, 1964.
5. Sarmiento, A. and Grimes, H. A.: The Use of the Austin T. Moore Vitallium Prosthesis in the Treatment of Acute Fractures and Other Diseases of the Hip, *Clin Orth* **12:** 120, 1963.
6. Stinchfield, Frank E.; Cooperman, B.; and Shea, C. E.: Replacement of the Femoral Head by Judet or Austin Moore Prosthesis, *JB&JtS* **39A:** 1043, 1957.
7. Hsu, John D.: Rehabilitation of Patients Suffering from Fracture of the Hip: Part I. Introduction and General Considerations, *Md Med J* **18:** 7, 111, 1969.
8. Quigley, T. B. and Banks, H.: *Progress in the Treatment of Fractures and Dislocations,* Philadelphia: W. B. Saunders Co., 1960.
9. Rowe, Carter R.: The Management of Fractures in Elderly Patients is Different, *JB&JtS* **47A:** 1043, 1965.
10. Hsu, John D.: Rehabilitation of Patients Suffering from Fracture of the Hip: Part II. Treatment by Hip Pinning, *Md Med J* **18:** 8, 89, 1969.
11. Cave, E. F. (ed.): *Fractures and Other Injuries,* Chicago: Year Book Pub., 1958.
12. Conwell, H. Earle and Reynolds, F. C. (eds.): *Key and Conwell. Management of Fractures, Dislocations, and Sprains,* ed 7, St. Louis: C. V. Mosby Co., 1961.

THE DAY OF THE LONE (INSURANCE / MUTUAL FUND) WOLF IS OVER

AN INCREASINGLY COMPLEX AND SOPHISTICATED WORLD HAS PASSED HIM BY

WE ARE A TEAM OF SPECIALISTS

ON OUR TEAM IS A SPECIALIST IN KEOGH PLANS
(HIS ARTICLES IN THIS FIELD ARE NATIONALLY KNOWN!)

ON OUR TEAM IS A SPECIALIST IN MUTUAL FUNDS
(IN CONSTANT CONTACT WITH OLD FRIENDS ON WALL STREET!)

ON OUR TEAM IS A SPECIALIST IN TAX-SHELTERED METHODS OF PURCHASING LIFE-INSURANCE AND MUTUAL FUNDS
(18 YEARS IN THIS FASCINATING AND COMPLEX SPECIALTY!)

ON OUR TEAM IS A SPECIALIST IN ACCIDENT AND SICKNESS INSURANCE
(30 YEARS IN THIS SPECIALTY!)

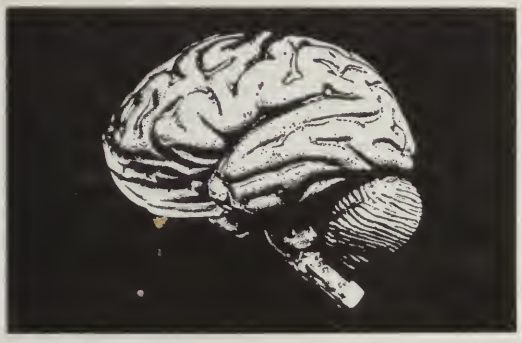
ON OUR TEAM IS A SPECIALIST IN ESTATE PLANNING
(KNOWN AND RESPECTED AS BOTH TEACHER AND PRACTITIONER!)

ALL THESE PEOPLE ARE AT YOUR SERVICE
(HOW CAN ONE MAN POSSIBLY COVER ALL THIS GROUND–IN DEPTH?!)

SECURITY HOUSE, Inc. and affiliates

539–5900

THE HOUSE OF SPECIALISTS
(IN INSURANCE AND MUTUAL FUNDS)



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Fact Sheet for 1969 Fiscal Year

In 1969, Maryland's hospitals for the mentally ill again treated a record number of patients, reflecting primarily the continuing rise in admissions of alcoholics. Ten years ago these facilities treated 15,853 patients; by 1969 this had increased 61.1% to 25,541. However, due to shortened periods of hospitalization of new admissions and the gradual, continuing decrease in the number of long term patients, the average daily size of the patient population declined 16.8% during this period from 8,952 to 7,451.

FISCAL YEAR	AVERAGE SIZE OF PATIENT POPULATION	TOTAL NUMBER TREATED DURING YEAR	ADMISSIONS	TOTAL SEPARATIONS
1959	8,952	15,853	4,164	4,367
1961	8,428	16,783	5,266	5,425
1963	8,218	18,726	7,257	7,173
1965	8,076	19,873	8,551	8,006
1967	8,006	22,899	11,091	11,298
1969	7,451	25,541	14,085	14,130
NET CHANGE	—1,501	+9,688	+9,921	+9,763
PERCENT CHANGE	—16.8	+61.1	+238.3	+223.6

A similar upward trend has been observed in virtually all private psychiatric hospitals, psychiatric units of general hospitals, clinics and other community centers reporting to the Maryland Psychiatric Case Register. For example, total admissions to the 102 clinics are estimated to have increased 10.5%, from 17,399 in 1968 to 19,220 in 1969. Since comparable data have been reported by other states, the question is frequently posed whether or not this reflects a rising incidence of mental illness. This cannot be readily answered since the numerical relationship between number of individuals treated in psychiatric facilities and total number of mentally disturbed or ill is not known. However, it is generally believed that the rate of occurrence of most mental illnesses has not changed appreciably and that these expanding figures, therefore, primarily reflect the growing acceptance and usage of psychiatric hospitals and clinics for the short-term, intensive treatment of alcoholism and acute psychoneurotic and personality disturbances. Recent legislation and court decisions have intensified these trends.

Rosewood, the larger of Maryland's two hospitals for the mentally retarded, last year operated at 21.0% in excess of capacity and, consequently, persisted in its policy of restricting admissions to available space and staff. Although the patient population has increased from 2,144 in 1959 to the current 3,090, Maryland's ratio of patients to total state population is 11.7% below the national average. In an effort to resolve this chronic problem, the Department is engaged in a three-pronged program involving (1) construction of new residential retardation facilities on a regional basis; (2) development with the Health Department of community-based services as alternatives to hospitalization; and (3) removing emotionally disturbed children from Rosewood, allowing conversion of two buildings for the care of the mentally retarded.



Skilled Hands

Skilled hands at Jobst Service Centers expertly measure your patient for a custom-made Jobst *Venous Pressure Gradient*® Support!

And *your* own prescription determines the precise counter-pressures to be built-in each garment! These selected counter-pressures can aid in moving pooled venous and lymph fluids, and offer a treatment of *choice* for varicose ulcers, varicose veins, stasis dermatitis, postmastectomy lymphedema, postphlebitic syndrome, post fracture, postoperative and injury edema.

Jobst Prescription *Venous Pressure Gradient* Supports include stockings, lymphedema sleeves and waist-high garments of many types. Jobst also makes special garments for unusual conditions.



For a complete data file on Jobst Garments, send coupon at right. Or even quicker, just call the phone number shown.

© Jobst 1969

Jobst Service Center

Suite 200, 818 Eighteenth Street, N.W.
Washington 20006, Phone (202) 298-5530

Suite 415, Medical Arts Bldg., 101 W. Read St.
Baltimore 21201, Phone (301) 539-0560

Name _____

Institution _____

Address _____

City, State, Zip _____



ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

Evaluation Service for the Elderly

A new service for Baltimore's older residents was inaugurated July 1 under the joint sponsorship of the Baltimore City Health Department, the State Commission on the Aging, and the Maryland State Departments of Health and Mental Hygiene. Known as the Geriatric Evaluation Service, the program will seek to reduce admissions of Baltimore city residents aged 65 and over to state mental hospitals, and to maintain as many as possible in their own homes. At present, approximately 400 patients aged 65 and over are admitted each year to Crownsville, Springfield and Spring Grove State hospitals from Baltimore city. The highest number of these admissions comes from Baltimore's inner city.

Funded by a federal grant under Title III of the Older Americans Act and a Community Mental Health Services Demonstration Grant from the State Department of Mental Hygiene, the service is available to everyone regardless of income.

Now located in the Good Samaritan Hospital on Loch Raven Boulevard, the service, under City Health Department administration, is designed to provide a pre-admission evaluation to Baltimore city residents aged 65 and over for whom mental hospital admission is contemplated. The evaluation will be made within the patient's own environment to assess his medical, psychiatric and social needs. If he can best be treated at home or in the community, assistance will also be provided in locating and using relevant resources.

The program's director, Mrs. Mary Guth, received her B.S. degree at Towson State College and her master's degree in social work from the University of Pennsylvania. Specializing as a psychiatric social worker, she has served at Spring Grove State Hospital, in community mental health clinics of county health departments throughout the state and most recently in the Baltimore City Health Department.

The program is presently funded through January 31, 1970. It is anticipated, however, that funds will be made available on a continuing basis to meet the growing mental health needs of our older population. Further information may be obtained by calling 323-2200, extension 279.

AKEHURST NURSERIES

RESIDENTIAL—COMMERCIAL—INDUSTRIAL LANDSCAPING

Joppa Road **Perry Hall, Md. 21128**
Phone: 665-7588 **Closed on Sundays**

Plantsmen for Four Generations

Baltimore's Young Bank

National City Bank

Light & Lombard Streets
6378 York Road

Route 40 West at Rolling Road
6515 Reisterstown Road

when it's late in life and anxiety and depression coexist...

initial therapy

Triavil® 4-10

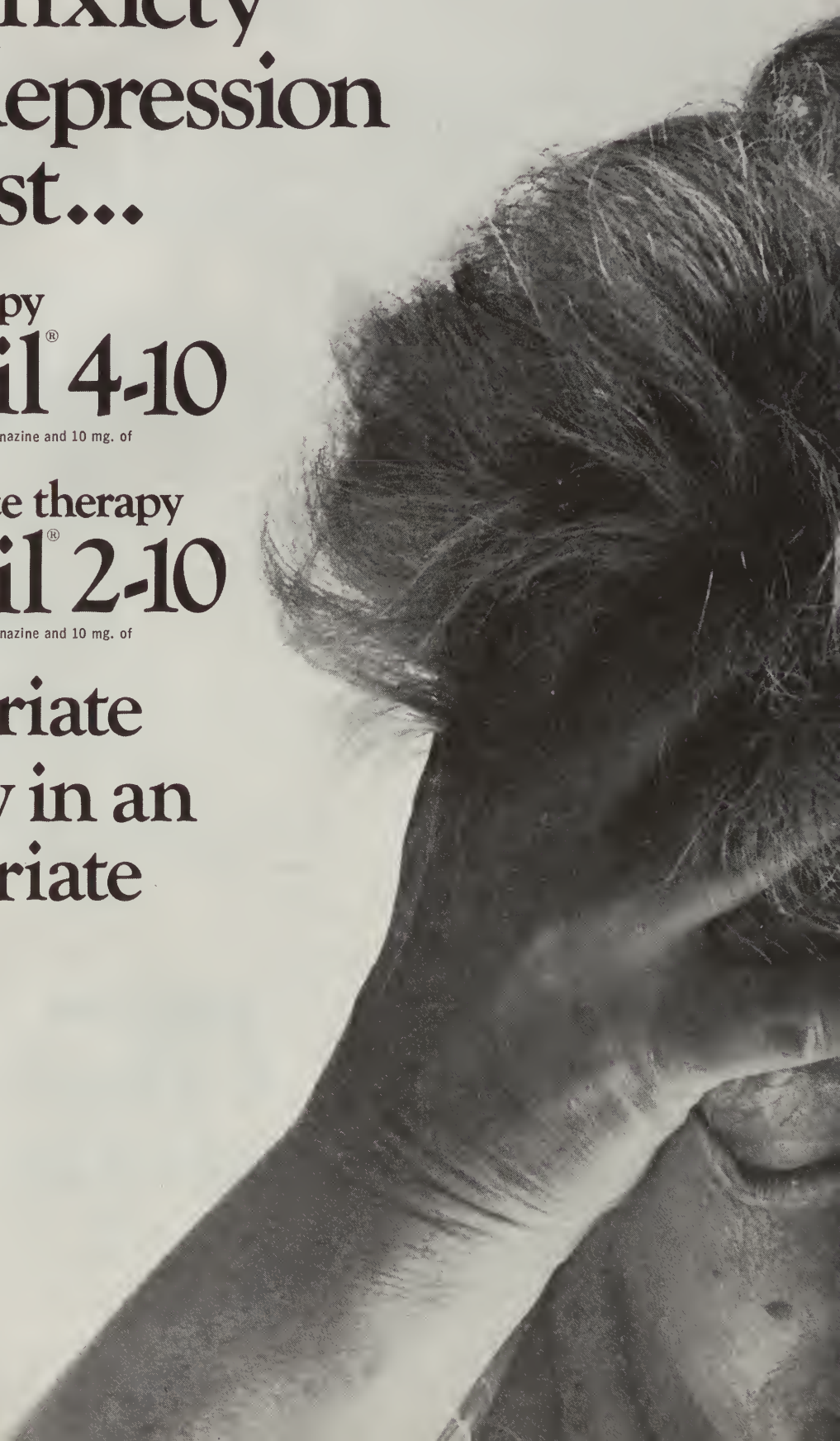
Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride

maintenance therapy

Triavil® 2-10

Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

appropriate therapy in an appropriate dosage





During the years of declining strength and increasing infirmity, many patients are more sensitive to both the desired response and the unwanted effects of some drugs. That's when low-dosage therapy is needed. And that's when TRIAVIL 4-10, as initial therapy, and TRIAVIL 2-10, for maintenance, can prove particularly useful.

Starting with TRIAVIL 4-10 should help minimize possible dose-related side effects in the geriatric patient with coexisting anxiety and depression. And, subsequently, TRIAVIL 2-10 can increase flexibility in adjusting maintenance dosage.

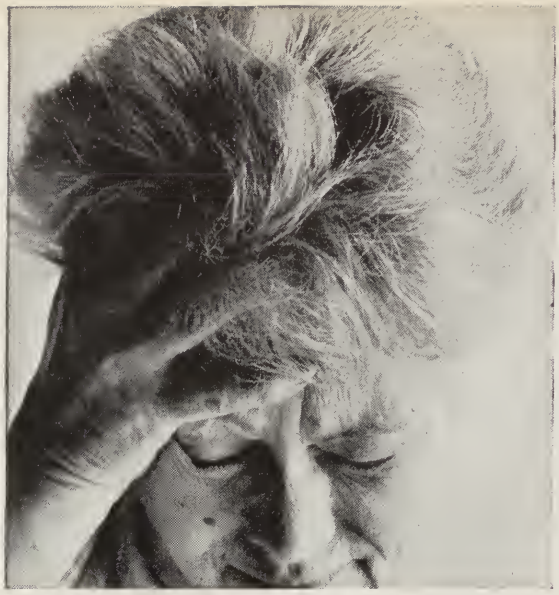
Activities made hazardous by diminished alertness should be avoided. You will want to inform your patients that the effects of alcohol may be potentiated. Because of the potentiation of other drug effects possible with MAO inhibitors, such agents should not be given concomitantly with TRIAVIL. However, therapy with TRIAVIL can be initiated cautiously two weeks or more after withdrawal of the MAOI drugs. And, until significant remission is observed, close supervision of any seriously depressed patient is, of course, essential to guard against possible suicide. The drug is contraindicated in glaucoma, in patients expected to experience problems of urinary retention, in drug-induced CNS depression, and in bone marrow depression.

TRIAVIL 4-10 & 2-10—tranquilizer-antidepressant therapy especially appropriate for the elderly patient so often intolerant to medication in high dosages.

TRIAVIL® **for moderate to severe anxiety with coexisting depression**

containing perphenazine and amitriptyline HCl
TRANQUILIZER-ANTIDEPRESSANT

For additional prescribing information, please see following page.



TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

TRIAVIL 4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.
TRIAVIL 2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.
TRIAVIL 4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.
TRIAVIL 2-10: For use in adjusting maintenance dosage. Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

for moderate to severe anxiety with coexisting depression

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory reponse.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

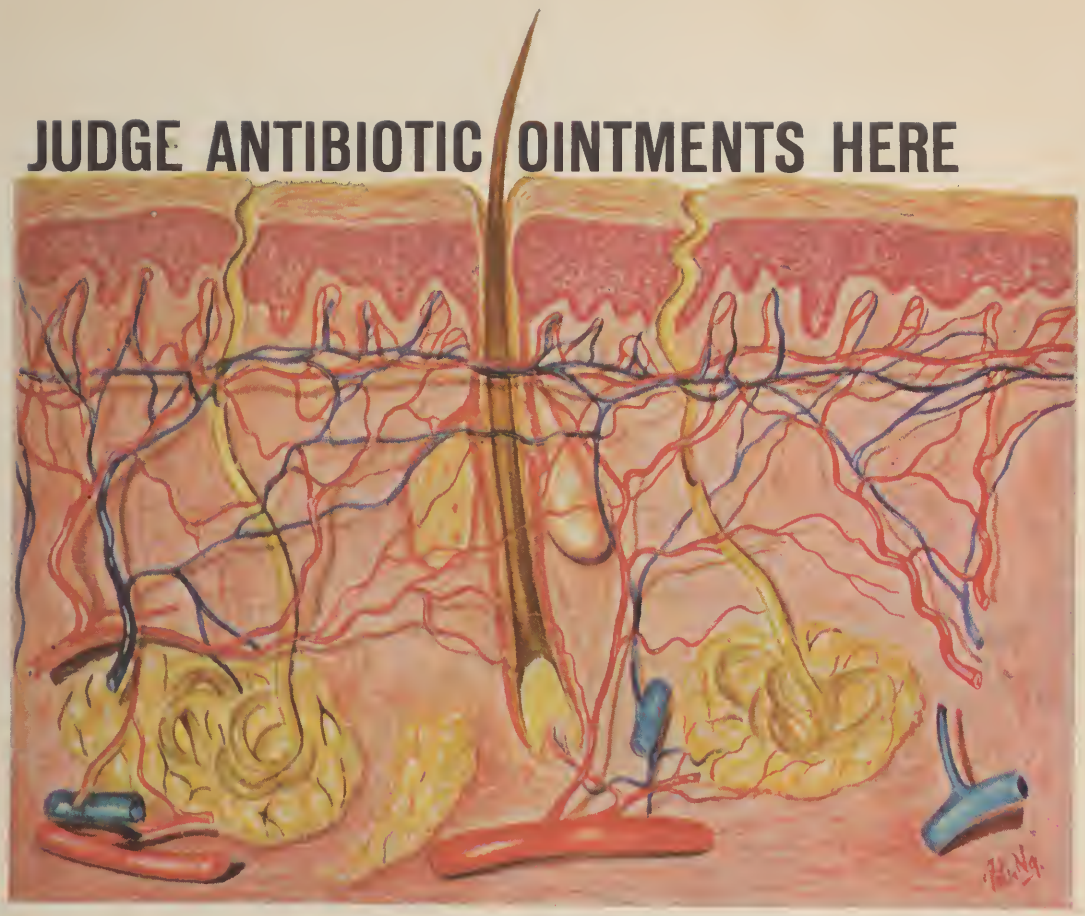
PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed, as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

SIDE EFFECTS: Similar to those reported with either constituent alone. **Perphenazine:** Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe, acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides. **Amitriptyline:** Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

Before prescribing or administering, read product circular with package or available on request.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co., Inc., West Point, Pa 19486
where today's theory is tomorrow's therapy

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

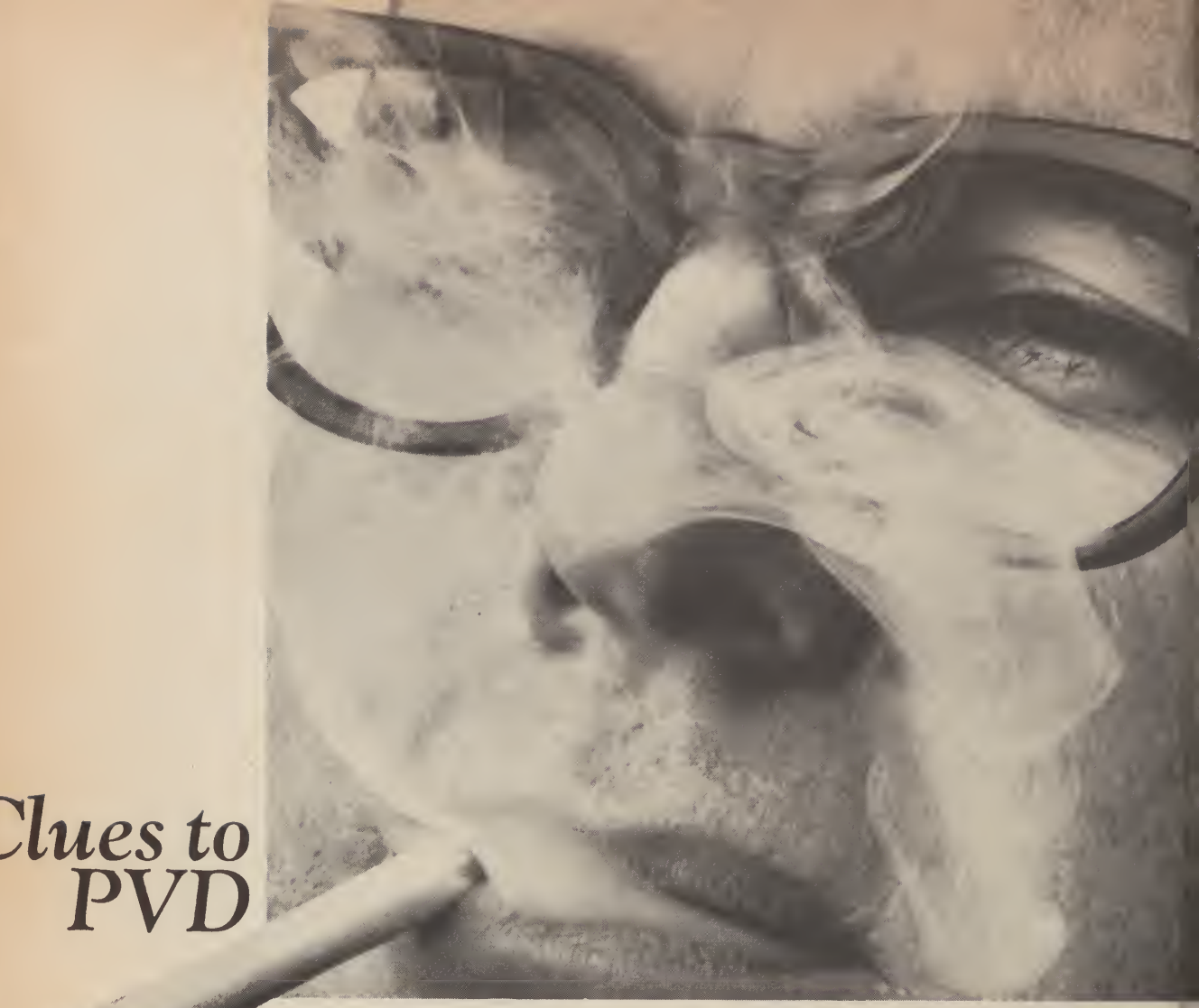
Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®
brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Clues to PVD



The heavy smoker with vasospasm

He may be comparatively young or approaching middle age. Typically, he is a heavy cigarette smoker—a pack or more a day for a number of years. Whether smoking is a causative or an important exacerbating factor in peripheral vascular disease is still under discussion. But the vasoconstrictive effects of nicotine are firmly supported by a substantial body of laboratory and clinical evidence, and the close association is now generally accepted.

Thus, a history of heavy smoking coupled with vasospasm may serve as warning signals to the physician. When a diagnosis is established, therapeutic measures are directed toward increasing the local circulation, and appropriate management of the patient's general medical needs should be instituted. These include the important safeguards of keeping warm and refraining from smoking.

Before prescribing Roniacol Timespan (nicotinyl alcohol tartrate), please consult complete product information, a summary of which follows.

Indications: Conditions associated with deficient circulation; *e.g.*, peripheral vascular disease, vascular spasm, varicose ulcers, decubital ulcers, chilblains, Meniere's syndrome and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets morning and night.

How Supplied: Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt —bottles of 50.



Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Important in total management of peripheral vascular disease, vascular spasm or chilblains

Roniacol® Timespan®

(nicotinyl alcohol tartrate)

for relief of ischemic symptoms

Convenience of b.i.d. dosage—sustained-release Timespan Tablets usually provide prolonged relief of ischemic symptoms with two doses daily.

Smoothness of onset—the action of Roniacol (nicotinyl alcohol) is smooth and gradual in onset, rarely causing severe flushing.

Selectivity of action—relaxes the musculature of peripheral blood vessels.

High degree of safety—side effects seldom require discontinuation of therapy.



Preludin®
phenmetrazine hydrochloride

Preludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).
Contraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.
Warning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.
Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.
Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.
Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.
Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000. (B)R3-46-560-B

Under license from
Boehringer
Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

They run a good chance of losing weight.

Exercise and Preludin run together in helping patients to lose weight.

Preludin often puts a curb on appetite and promotes a sense of well-being. By boosting a dieter's spirit, Preludin may help patients get the exercise you may prescribe.

One Endurets tablet taken between breakfast and midmorning usually provides daylong and early-evening suppression of appetite.

A few patients may experience overstimulation or insomnia. For a brief summary of all adverse reactions, precautions, warning and contraindications, please see the adjoining page.

Preludin® phenmetrazine hydrochloride **Endurets®** prolonged-action tablets

Geigy

Extra Dollars

for you—with Chesapeake's

EXTRA ¼% DIVIDEND

anticipated for the quarterly dividend period ending Sept. 30.
next dividend period
Oct. 1 to Dec. 31

Chesapeake Federal

SAVINGS & LOAN ASSOCIATION

2240 EASTERN AVE. Corner PATTERSON PARK

ORLEANS 5-6602

The Robert Morris Inn — 1710

ON THE SCENIC TRED AVON RIVER, OXFORD, MD.



Dinner—5:30 to 10 P.M. Lunch—11:30 A.M. to 2:30 P.M. Sunday Dinner—1:30 to 9 P.M.

In a quaint tree-lined village, the ROBERT MORRIS INN is an architectural tribute to 18th Century America. Here is beauty, serenity and varied recreation—including sailing, fishing, tennis, golf, bowling. Only 10 miles from Route 50, and 90 minutes from Baltimore or Washington. . . .

Write for our brochure.

DINING ROOM
TAP ROOM
TAVERN
PACKAGE LIQUOR
ROOMS



Visit Us Soon

OXFORD, MARYLAND
CA 6-5111



Apply internally.

Take a relaxing break for Coca-Cola. Couple of times a day. Because Coke has the taste you never get tired of. It's always refreshing.



MRS. FRANK A. FARAINO, EDITOR

Vivacious New President:

Mrs. Wallace H. Sadowsky

Mrs. Wallace H. Sadowsky of Havre de Grace, Maryland, was installed as President of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland at the 20th Annual Convention on April 10, 1969. Mrs. Sadowsky has been active in medical auxiliary work since 1960, when she was one of the founding members of the Woman's Auxiliary to the Harford County Medical Society; she later served as president of that organization. She has served on the Board of the State Auxiliary since 1961, when she was its secretary. Since then, she has been a vice president for four years and has been elected president-elect twice, having had to resign late in her first term as president-elect due to illness. She has also served the State Auxiliary as Publicity Chairman, AMA Education and Research Foundation Chairman for two years, Representative to Med-Chi's Public Relations Committee for two years, and as Membership Chairman.

Mrs. Sadowsky (Bea) is very proud of her Maryland heritage, having been born in Scotland, St. Mary's County, where Maryland was founded, educated in the Maryland public schools, and having attended the University of Maryland. In high school she was Valedictorian of her graduating class and received the Good Citizenship Award of the DAR. At the University of Maryland she was a member of the Phi Sigma Sigma Sorority and the Alpha Lambda Delta Honorary Fraternity.

Bea feels very close to the profession of medicine; not only is she married to a physician-surgeon, but she has two brothers who are physicians, Drs. Louis and Joseph Shuman.

Dr. and Mrs. Sadowsky have four daughters: Natalie, a recent graduate of Boston University and now a medical social worker at Beth Israel Hospital in Boston; Jocelyn, a sophomore at Mary Washington College of the University of Virginia; Shelley, a high school senior; and Iris, a high school freshman. All of their daughters are honor students, and have studied piano at the Peabody.



Mrs. Sadowsky

In addition to medical auxiliary work, Bea serves on the Harford County Board of Directors of the

American Cancer Society. She has been active in Girl Scouts, Homemakers Club, PTA, Harford Memorial Hospital Auxiliary, Hadassah, Harford Jewish Center Board of Directors, and Ladies Auxiliary.

Bea urges that all physicians' wives become active members of the Medical Auxiliary. In her inaugural address she said, "There are enough facets in our work that every physician's wife can easily find one area in which she can be effective. If we can help one alcoholic, discourage one youth from trying narcotics, provide one student with a nurse's education, make one loan to a needy medical student, provide one piece of needed equipment for an overseas physician or hospital, make one person aware of medical quackery, detect one diabetic, immunize one child from measles, and prevent the passing of one piece of poor medical legislation, then we will have served effectively and truly lived up to our motto of 'HYGEIA FILIAE'—Handmaidens to Health." She said that small auxiliaries need not be apologetic for their few members, but should be proud to have an organization. "Getting together and promoting fellowship is one of the important facets of an Auxiliary program. Some day a need may arise and this small group can be ready to fill it." Bea feels it is a privilege to serve. She asserted that ". . . we must make communities everywhere aware that physicians and physicians' wives play a comprehensive role in health planning and care . . . . Auxiliaries can help build appreciation, understanding and goodwill for the medical profession, for indeed they are 'built-in' public relations ambassadors."

Serving with Mrs. Sadowsky on the Board of the Woman's Auxiliary are the following:

Mrs. Raymond M. Yow, President-elect and Membership Chairman

Mrs. Elmer G. Linhardt, 1st Vice President and AMA-ERF Chairman

Mrs. DeWitt E. DeLawter, 2nd Vice President and Legislation Chairman

Mrs. R. Kennedy Skipton, 3rd Vice President and Convention Chairman

Mrs. Robert J. Dawson, 4th Vice President and Health Careers Chairman

Mrs. Edgar E. Folk, III, Recording Secretary

Mrs. Sullins G. Sullivan, Treasurer

Mrs. Richard D. Bauer, Corresponding Secretary

Mrs. Karl F. Mech, Parliamentarian

Mrs. Harold P. Biehl, Children and Youth Chairman

Mrs. G. Allen Moulton, Community Service Chairman

Mrs. Max R. English, Convention Co-chairman

Mrs. George S. Malouf, Disaster Preparedness-Safety Chairman

Mrs. Howard N. Weeks, Doctors' Day Chairman

Mrs. Frank A. Faraino, Editor, Auxiliary Page of *Maryland State Medical Journal*

Mrs. M. McKendree Boyer, Finance Chairman

Mrs. Thaddeus Elder, Health Careers Co-chairman

Mrs. William S. Stone, Historian

Mrs. James L. Garey, Hospitality Chairman

Mrs. Leopoldo Gruss, International Health Activities Chairman

Mrs. Albert E. Goldstein, Liaison to Woman's Auxiliary to Student AMA (WA-SAMA)

Mrs. Albert F. Cooper, Members-at-Large Chairman

Mrs. Peter P. Rodman, Mental Health Chairman

Mrs. Gerald Palmer, Mental Health Co-chairman

Mrs. John E. Baybutt, Editor of Newsletter, "HYGEIA FILIAE"

Mrs. Charles Mawhinney, Press and Publicity Chairman

Mrs. John Umhau, Program Chairman

Mrs. H. Leonard Warres, Representative to Med-Chi Public Relations Committee

Mrs. Henry P. Laughlin, Revisions and Resolutions Chairman

Mrs. Archie R. Cohen, Councilor to Woman's Auxiliary to the Southern Medical Association

Mrs. David S. Clayman, Vice-Councilor to Woman's Auxiliary to the Southern Medical Association

Visit the #1 Spot for Your Diet Needs
Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)
For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic
SPECIAL DIET SHOP
Phone SA 7-0383

Mercedes-Benz does not make conventional cars... and never will!
TOWSON VALLEY MOTORS
Mercedes-Benz
103 E. Pennsylvania Ave., Towson (Just behind Hutzler's) 821-8000



JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Lipoprotein Phenotypes

LAWRENCE F. MISANIK, MD
Director of Laboratory
St. Joseph Hospital, Towson, Maryland

In recent years, there has been considerable interest in patients with hyperlipidemias, and the work of Fredrickson, Levy, and Lees [1] who introduced a method of classification of these disorders, has done much to increase this interest. Although their approach was developed, primarily, to study the genetically-determined disorders of lipid metabolism, it has also been useful in dealing with the problems of acquired hyperlipidemias. In fact, some of the therapeutic modalities available for treatment of the primary groups can be useful in the management of the acquired hyperlipidemias.

Although large-scale studies with long-term follow-up remains to be done before the efficaciousness of the therapy can be evaluated, it would seem that the frequency of occurrence of atheromatous cardiovascular disease would indicate that patients having certain types of hyperlipidemias should have their abnormal biochemical parameters corrected by judicious selection and use of dietary restriction and medication.

To apply these corrective modalities would require the recognition of patients with these disorders and classification of their abnormality.

Clinical Manifestations. Frequent features seen in hyperlipidemias include the presence of xanthomas of various types occurring in various locations: eruptive xanthomas, xanthelasma, tuberous xanthomas, and tendinous xanthomas. Deposits of lipids in the creases of the palms may be evident, giving rise to yellow striae. Arcus senilis can be found. In addition, some of these patients may be subject to accelerated occlusive arteriosclerotic cardiovascular disease. Patients may have abdominal pain which can be associated with an elevation of serum amylase or lipase. If these patients are subjected to an exploratory laparotomy, a milky fluid may be found intraperitoneally. Obesity may be present.

Other findings which may warrant cause for concern are the presence of a lactescent serum, abnormal glucose tolerance test, diabetes mellitus, hyperuricemia, and an elevation in serum cholesterol.

Patients having secondary hyperlipidemias will have the clinical findings of their primary disease state. Secondary hyperlipidemia occurs in hypothyroidism, nephrosis, hepatic disease, dysproteinemias (myeloma, cryoglubulinemia, and macroglobulinemia), pancreatitis and alcoholism, idiopathic hypercalcemia, patients on progestational drugs, and diabetes mellitus.

Differential Diagnosis. Faced with a patient possibly having a hyperlipidemia, one must attempt to classify the disease process so that proper therapy can be instituted. In the classification of Fredrickson et al the abnormalities of lipid metabolism have been translated to abnormalities of lipoproteins, as detectable by lipoprotein electrophoresis in conjunction with triglyceride and cholesterol determinations.

To correctly interpret the data obtained from these studies, certain precautions must be followed before these studies can be undertaken. The patient must be on a normal diet for at least 7-14 days before his serum lipid pattern can be studied. After the patient has fasted for 12-14 hours, the specimen must be collected in a vacutainer containing EDTA as the

anticoagulant. The specimen should be taken to the laboratory immediately, or if this is not possible, the plasma must be separated and the specimen refrigerated. Do not freeze the sample. The test sample should be delivered to the laboratory as soon as possible.

The tests requested should include cholesterol, triglycerides, and lipoprotein electrophoresis. The latter need not be done if the serum cholesterol and triglycerides are clearly within normal limits, for this adequately rules out hyperlipidemias. However, it may be necessary for proper classification to repeat these analyses or to perform these determinations on the patient's family.

The keystone to classification is lipoprotein electrophoresis. In case of lipoprotein electrophoresis, the paper is stained with a fat-soluble dye that stains the molecules of protein that contain fat. This allows a pattern to emerge. There are usually three bands visible in a lipoprotein electrophoretogram. They are called beta lipoprotein, pre-beta lipoprotein, and alpha lipoprotein. In certain abnormal patterns, a fourth band can be found which is due to the presence of chylomicrons.

Types of Hyperlipoproteinemia: Type I—Exogenous Hyperlipidemia

This is an exogenous hyperlipidemia that is usually familial, rare, and characterized by elevations of cholesterol, triglycerides, and chylomicrons. The plasma from patients exhibiting these characteristics is creamy in appearance. Clinically, these patients have hepatosplenomegaly, eruptive xanthomas, lipemia retinalis, and periodic episodes of abdominal pain that may or may not be associated with increases in serum amylase and lipase. Investigations indicate that these patients have a deficiency in a lipoprotein lipase, which leads to a decrease in the clearing of exogenous triglycerides and cholesterol, leading to an excess in circulating chylomicrons.

Infrequently, one finds this type of hyperlipoproteinemia occurring as an acquired defect in patients with hypothyroidism, alcoholism and pancreatitis, and lupus erythematous.

Evidently, the presence of these chylomicrons does not produce accelerated atherosclerosis. Treatment consists of a moderate reduction of fat in the diet.

Type II—Hyper-beta Lipoproteinemia

This type is a very common disturbance of lipid metabolism and is characterized by an elevation of beta lipoprotein and cholesterol, with a lesser increase in triglycerides. It can occur both as a primary or an acquired form. Xanthomas are frequently found and can be tendinous and tuberous, occurring over the extensor surfaces of the extremities. Arcus senilis is common; accelerated coronary artery disease is frequently seen. The diagnosis of the primary type is dependent upon the demonstration of the lipoprotein abnormalities in both parents; or in one of the parents with the occurrence of xanthomata in the investigated patient by the age of ten years.

The acquired Type II hyperbeta lipoproteinemia can be found usually in obstructive hepatic disease, myxedema, nephrosis, and rarely in other diseases, such as, dysproteinemias and idiopathic hypercalcemia. It may also arise from excess in dietary cholesterol and saturated fats.

Treatment for the acquired form of the disease should be directed towards the primary disorder. The familial type can be managed by dietary means (low cholesterol with supplemented polyunsaturated fats) and medication. Medications include cholestyramine, beta-sitosterol, estogens, and clofibrate *(Atromid-S)*.

Type III—Broad Beta Band Disease

This type appears to occur only in the primary form. The plasma may be clear, cloudy, or milky. This type is characterized by a broad beta lipoprotein band by electrophoresis with elevations of serum cholesterol and serum triglycerides. Clinically, it is associated with xanthomata and characteristically, lipids can be deposited in the palmar creases. Associated findings can be mild diabetes mellitus and accelerated arteriosclerotic disease.

This type of hyperlipoproteinemia is very sensitive and responsive to variations in daily cholesterol and saturated fat intake, and can be controlled by dietary means. Clofibrate can also be useful.

Type IV—Endogenous Hyperlipidemia

These patients have a normal or elevated cholesterol; elevated triglycerides; clear, cloudy, or milky serum; and an elevation in the pre-beta fraction of the lipoprotein electrophoretogram. These patients tend to be obese and have eruptive xanthomata, lipemia retinalis, and bouts of abdominal pain. Hyperuricemia can occur. Frequently they have an abnormal glucose tolerance test. Accelerated arteriosclerosis is seen in this group of patients.

The secondary or acquired Type IV endogenous hyperlipidemia is found in patients with diabetes mellitus. In fact, patients with diabetes mellitus and acquired Type IV endogenous hyperlipemia may be difficult to separate from the primary form.

The secondary form can also be seen in pancreatitis with alcoholism, hypothyroidism, dysproteinemia, progestational drug therapy, gout, and other rare disease states. Treatment consists of weight control, decrease in carbohydrate intake, and the use of hypolipemic agents, such as, clofibrate, nicotinic acid, and heparin.

Type V—Mixed Hyperlipidemias

These patients have an elevation of cholesterol, triglycerides, and an increase in chylomicrons and pre-beta lipoproteins. The plasma appears creamy.

These patients may have eruptive xanthomas, lipemia retinalis, and abdominal pain. The patients are frequently obese and there is a history of familial diabetes mellitus and obesity. Hyperuricemia may be seen. Evidence of accelerated atherosclerosis has been striking.

Secondary forms occur in patients with diabetes mellitus, chronic pancreatitis, and recent alcoholic intake.

Management includes weight reduction by using a diet low in carbohydrates and fat, and clofibrate.

REFERENCE

1. Fredrickson, D. S.; Levy, R. I.; and Lees, R. S.: Fat Transport in Lipoproteins: An Integrated Approach to Mechanisms and Disorders, *New Eng J Med* **276:** 34, 94, 148, 215, 1967.

A & F Nurses Registry



Registered & Licensed

LICENSED & BONDED

- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.

BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#801—65 Poly./35 cot. Tricot **$6.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only

Sizes 34 to 46





MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab **$9.99**

Sizes 28-40

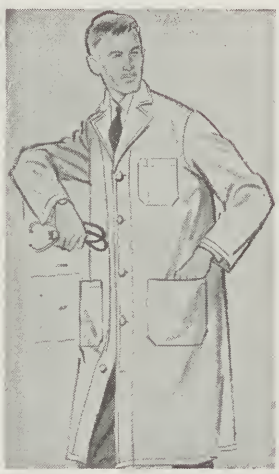
- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46



OTHER STORES IN →

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of te weight-control program *you* recommend It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in patients hypersensitive to this drug; in emotionally unstable patnts susceptible to drug abuse.

Warning: Although generally safer than the amphetamines, use with great caution in patients with severe hypertension or severe cardiovascular disease. Do not use during first trimester of pregnancy unless potential benefits outweigh potential risks.

Adverse Reactions: Rarely severe enough to require discontinuation of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence.

As is characteristic of sympathomimetic agents, it may occasionally cause *CNS effects* such as insomnia, nervousness, dizziness, anxiety, and jitteriness. In contrast, CNS depression has been reported. In a few epileptics an increase in convulsive episodes has been reported.

Sympathomimetic *cardiovascular effects* reported include ones such as tachycardia, precordial pain, arrhythmia, palpitation, and increased blood pressure. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride; this was an isolated experience, which has not been reported by others.

Allergic phenomena reported include such conditions as rash, urticaria, ecchymosis, and erythema.

Gastrointestinal effects such as diarrhea, constipation, nausea, vomiting, and abdominal discomfort have been reported.

Specific reports on the hematopoietic system include two each of bone marrow depression, agranulocytosis, and leukopenia.

A variety of miscellaneous adverse reactions have been reported by physicians. These include complaints such as dry mouth, headache, dyspnea, menstrual upset, hair loss, muscle pain, decreased libido, dysuria, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additional tablet may be given in midevening to overcome night hunger. Use in children under 12 years of age is not recommended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



symptoms of mixed anxiety-depression are rarely clear-cut

but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Federal Grant Approved for Family Planning Program

The Division of Maternal and Child Health received notification that a $165,287 federal grant has been approved to expand family planning services in Prince George's, Charles, and Calvert Counties.

The federal grant, awarded by the Children's Bureau of the US Department of Health, Education, and Welfare, will enable the local health departments in these three counties to increase the number of clinic sessions and to strengthen their educational programs for family planning.

The grant is helping to finance Phase I of a three-phase program which, by 1974, should provide family planning services for more than 80% of the women in these counties who request such services. Hopefully, as additional federal funds become available, the expanded program will be offered throughout the state.

Records show a slow, but steady, increase in the number of subdivisions in Maryland which provide family planning services. From four subdivisions conducting such clinics in 1962, the number increased to seven by 1963, and fourteen by 1964. At present, family planning clinic services are provided in the local health departments in all of the 24 subdivisions.

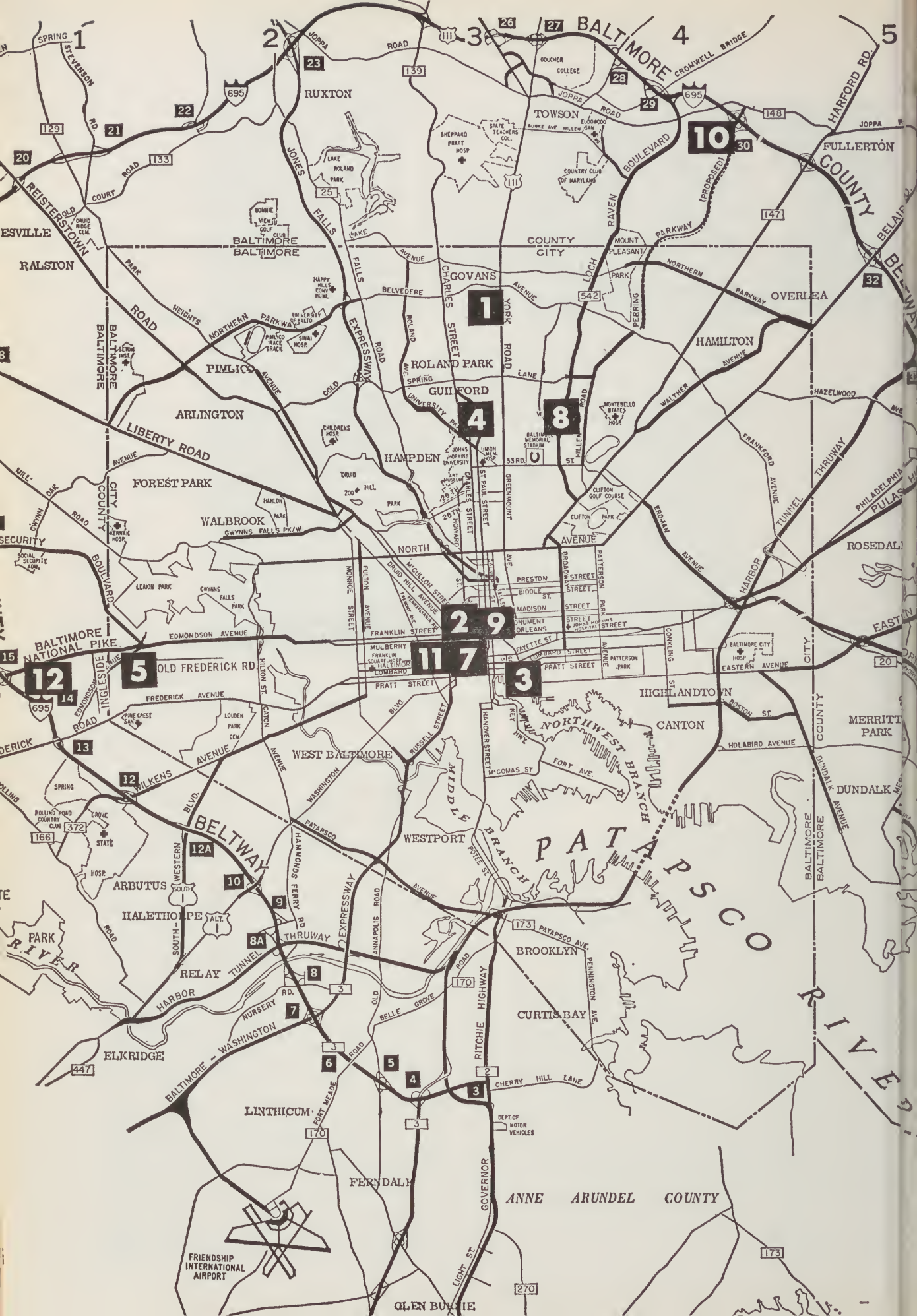
For the fiscal year 1967, there was a total of 691 combined Maternity and Family Planning Clinic sessions and 367 Family Planning Clinic sessions held in the 23 counties. Exclusive of Baltimore, 6,448 patients were seen in fiscal year 1967. This included 1,847 patients seen in clinics conducted in Montgomery County by Planned Parenthood, Inc., Washington, D.C. In Baltimore city, clinics are conducted in the outpatient departments of seven of the hospitals and in health department locations, and at locations of Planned Parenthood of Maryland, Inc.

In 1968, Family Planning clinics in all districts of Baltimore city served over 6,200 patients. Additional physician and nursing staff has been obtained to care for the rapidly increasing caseload of the Family Planning Clinics. The Model Cities Program is expected to be of great assistance in determining areas of need for new sites for Family Planning Clinics which should move out of primarily medical settings and still maintain high quality medical care.

The ultimate objective of the Family Planning Program is that all families in Maryland may have free choice in determining the spacing of their children and the size of their families.

In working toward this objective, the program respects the principle that freedom of choice implies that there are alternatives between which families may choose, and that families must be able to know something about these alternatives, including their possible consequences.

The program recognizes that in the area of family planning this element of choice relates to the health of the mother and child or children and to the quality of life parents wish to have for themselves and their children.


1
2
3
4
5
BALTIMORE
RUXTON
TOWSON
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
ARLINGTON
PIMLICO
FOREST PARK
WALBROOK
HAMILTON
OVERLEA
FULLERTON
COUNTY
BELAIR
RALSTON
LIBERTY ROAD
BALTIMORE NATIONAL PIKE
OLD FREDERICK RD.
FREDERICK AVENUE
WEST BALTIMORE
NORTH AVENUE
PRATT STREET
FRANKLIN STREET
MADISON STREET
PRESTON STREET
EDMONDSON AVENUE
HIGHLANDTOWN
CANTON
MERRITT PARK
DUNDALK
NORTHWEST BRANCH
MIDDLE BRANCH
PATAPSCO RIVER
WESTPORT
ARBUTUS
HALETHORPE
BELTWAY
RELAY TUNNEL
BROOKLYN
CURTIS BAY
ELKRIDGE
LINTHICUM
FERNDALE
ANNE ARUNDEL COUNTY
GLEN BURNIE
FRIENDSHIP INTERNATIONAL AIRPORT
BALTIMORE - WASHINGTON
HARBOR TUNNEL THRUWAY
BALTIMORE CROMWELL BRIDGE
HARFORD RD.
JOPPA ROAD
REISTERSTOWN ROAD
CHARLES STREET
YORK ROAD
FALLS ROAD
EXPRESSWAY
RAVEN BOULEVARD
LOCH RAVEN
PERRING PARKWAY
NORTHERN PARKWAY
FRANKFORD AVENUE
HARBOR TUNNEL THRUWAY
PHILADELPHIA
ROSEDALE
EASTERN AVENUE
BALTIMORE CITY HOSP.
PATTERSON PARK
CONKLING
BROADWAY
GREENMOUNT
HILLEN
ST. PAUL STREET
HOWARD
LOMBARD
PRATT
FAYETTE ST.
MULBERRY
FRANKLIN SQUARE HOSP.
BALTIMORE
UNION MEM. HOSP.
JOHNS HOPKINS HOSPITAL
JOHNS HOPKINS UNIVERSITY
BALTIMORE MEMORIAL STADIUM
MONTEBELLO STATE HOSP.
CLIFTON GOLF COURSE
CLIFTON PARK
HAZELWOOD AVE.
WALTHER AVENUE
FROMAN AVENUE
HARBOR
PATAPSCO AVE.
PENNINGTON AVE.
RITCHIE HIGHWAY
CHERRY HILL LANE
DEPT. OF MOTOR VEHICLES
GOVERNOR
LIGHT ST.
FORT MEADE
OLD BELLE GROVE ROAD
ANNAPOLIS ROAD
HANOVER STREET
RUSSELL STREET
MCCOMAS ST.
FORT AVE.
HOLABIRD AVENUE
BOSTON ST.
EASTERN AVENUE
WASHINGTON BLVD.
PATAPSCO
NURSERY RD.
HAMMONDS FERRY RD.
SOUTH-WESTERN
ALT. 1
PARK
RIVER
ROLLING ROAD COUNTRY CLUB
PINE CREST SAN.
LOUDEN PARK CEM.
LEAKIN PARK
GWYNNS FALLS PARK
HANLON PARK
DRUID HILL PARK
DRUID HILL AVENUE
MCCULLOH ST.
MONROE STREET
FULTON AVENUE
HILTON ST.
CATON AVENUE
INGLESIDE AVENUE
EDMONDSON ROAD
GWYNN OAK
CITY COUNTY BOULEVARD
SECURITY
SOCIAL SECURITY ADM.
SINAI HOSP.
PIMLICO RACE TRACK
UNIVERSITY OF BALTO.
BONNIE VIEW GOLF CLUB
DRUID RIDGE CEM.
LAKE ROLAND PARK
HAPPY HILLS CONV. HOME
SHEPPARD PRATT HOSP.
STATE TEACHERS COL.
COUNTRY CLUB OF MARYLAND
GOUCHER COLLEGE
ELDERSLIE
BURKE AVE.
HILLEN
MOUNT PLEASANT PARK
(PROPOSED)
BALTIMORE
BALTIMORE
BALTIMORE
BALTIMORE
1
2
3
4
5
6
7
8
8A
9
10
11
12
12A
13
14
15
20
22
23
25
26
27
28
29
30
32
111
129
133
139
147
148
166
170
173
270
372
447
542
695

Restaurants of Distinction

Locations indicated by numbers on map

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD

Cocktails Mexican Beers

Tuesday thru Sunday

Open 5:00 P.M.---12:00 P.M.

Dinner and Snacks

Closed Monday

Phone 435-9858

Fine Restaurants

Recommended for

Your Dining Pleasure

6

MILTON INN

Circa 1740

Dine Amid Early American Charm
Warm, Gracious and Inviting

Selected By Life & Time Magazines
as One of America's Finest Inns

Lounge & Dining Room Available
for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.

SPARKS 771-4366

9

Cork 'n Bottle Restaurant

STEAK – SEAFOOD – PRIME RIB
COCKTAILS
LUNCHEON – DINNER

Major Credit Cards Honored

Private Party Rooms

22 E. FAYETTE ST. BALTIMORE, MD.

½ Block from Charles Center

539-1268

5



Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS

Finest Sea Foods
Prime Meats

5653 Old Frederick Road

East of Ingleside Ave., off Baltimore National Pike

TED KUCHTA, *Manager* Phone 744-0223

11

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*

Your Host
Tom d'Anna

539-9021



8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

3

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

Baltimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center

Open 12 noon to 3 A.M.–Closed Mondays

For Reservations Call 685-2811

2 blocks south of the Flag House

300 ALBEMARLE STREET

10



SPECIAL AT THE

FABULOUS CLUB VENUS

An Evening for Two . . Only $15

Offer good every night except Saturday

Make Reservations Now

Perring Plaza Shopping Center—Beltway Exit 30

For Reservations Call NO 8-2232

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE

Baltimore 1, Md. MU 5-6790

CARRY-OUT SERVICE

SPECIAL LUNCHEON and DINNERS

PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.

Sunday 12 Noon to 3 A.M.

4

Broadview Restaurant

Cocktails • Dinners • Luncheons

Private Entertaining Facilities

116 W. University Parkway at 39th St.

CALL CH 3-1216

7

Miller Bros.

"The Place to Eat"



NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call 752-4822

DESIGNS FOR
BUSINESS
INTERIORS

Koch Associates

108 SOUTH ST., BALTIMORE, MARYLAND

837-5400

A DIVISION OF THE KOCH OFFICE SUPPLY CO.

attention doctors--

When you guard the health of your funds by investing them where they are safe and accessible, you're practicing preventive medicine against inflation. And, funds grow at a gratifying rate through DAILY compounding of dividends.

5.23%
ON
PASSBOOK
ACCOUNTS
Effective
Annual Yield
Compounded
& Computed
DAILY

Guaranteed Protection
Accounts insured up to $20,000 by the Maryland Savings Share Insurance Corp.

SECURITY
Savings & Loan
(a stock corporation) Organized 1895



24 E. Fayette at St. Paul Street Phone: 727-4415

Advertisement

AN ANNOUNCEMENT TO MARYLAND PHYSICIANS WHOSE PATIENTS HAVE CHRONIC SLEEP DISTURBANCE

Recent advances in sleep research have made it possible to measure a variety of sleep disorders in otherwise normal patients.

To further these studies a clinic is being established at the Maryland State Psychiatric Research Center under the direction of Dr. Clinton Brown, Chief of Basic Sciences Research.

The primary purpose of this clinic will be to investigate the variables producing insomnia so that more effective treatment approaches may be formulated.

Of interest are: 1) the personality configuration, 2) sleeping habits and 3) psychophysiologic reactivity of the patient with chronic complaints of inability to fall asleep, frequent or early awakenings, somnambulism, enuresis or nightmares.

Individuals accepted for study will be given a physical exam, interview, psychometric test and polygraph recordings obtained during sleep.

Patients will be accepted by referral only and a diagnostic report will be furnished to the referring physician at the conclusion of the study.

Partial support for this project is being furnished by Friends of Psychiatric Research, a non-profit research foundation. While fees will not be charged, voluntary contributions by patients to offset study costs will be welcomed.

Additional information or appointment may be obtained by calling Mrs. Zaborowski at 744-8700, Ext. 252, 10 A.M. to 4 P.M. Monday thru Friday.

Albert A. Kurland, M.D., Superintendent.

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass
cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tub sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusic

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

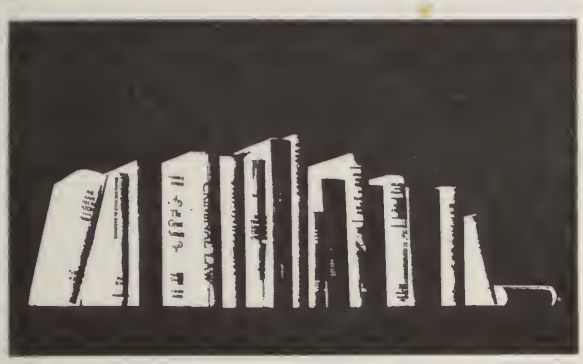
*For injectables not yet in the ever-expanding prefilled Tub line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

History of the Library of the Medical and Chirurgical Faculty of Maryland

During the past year a student from the University of Maryland School of Library and Information Sciences visited our library to research the historical information available toward the preparation of an assignment for a project on Maryland library history. We were pleased and a bit flattered that she had chosen to spend her efforts on this particular library.

Many days she spent digging into our files and history collection, often finding items we scarcely knew were around. Finally, when I returned from Amsterdam and the International Congress on Medical Librarianship, there was a copy of the paper by Mary Hope Wilson (Mrs. David) and also a note announcing the arrival of a young son. Fortunately, he was considerate enough to let his mother finish her library school semester and our history before arriving!

The paper presents a very clear picture of the evolution of this library, written in easy, flowing style. We are grateful for this study and it will be made available for circulation later.

* * *

MEDIC Tapes and Slides now Available

Med-Chi Library now has a complete collection of the slides and tapes used with the MEDIC programs. These may be borrowed by physicians on the same basis as books, with a loan period of four weeks, and one renewal allowed, if needed. Please give full information on subject, name of lecturer if known, and date presented, so that no mistake will be made in identifying request. Also, these as well as other requests may be phoned in directly to the library via the MEDIC telephone line. Why don't you try this service?

* * * * * *

Meetings

The Baltimore Hospital Librarians Association met September 25, 1969 at the U.S. Public Health Service Library.

The tentative date for the regional meeting of the Medical Library Association is November 22, 1969 in Bethesda. National Institutes of Health and National Library of Medicine are co-hosts.

Medical Library Association annual meeting will be held in Louisville, Kentucky, October 26-30, 1969 with headquarters in the Brown Hotel.

* * * * * *

New Accessions

BOOKS

(Arranged by author and title)

Ackerknecht, Erwin Heinz.
Short history of psychiatry. New York, Hafner Pub. Co., 1968.

American Association of Homes for the Aging.
Directory of non-profit homes for the aged, 1962. New York, 1962.

American Book publishing record. New York, Bowker, 1968.

American College of Physicians.
Directory, 1969. Chicago, 1969.

American drug index. Philadelphia, Lippincott, 1969.

American Medical Association.
Directory of approved internships and residencies, 1969.

American Medical Association. Archive-Library Department.
Index to medical socioeconomics literature. Chicago, 1968.

American Society of Anesthesiologists.
Directory of members, July 1969. Chicago, The society, 1969.

American Surgical Association.
Transactions. v. 86, 1968. Philadelphia, 1968.

Anderson, William Arnold Douglas.
Synopsis of pathology. 7th ed. St. Louis, Mosby, 1968.

Aspects of anxiety. Philadelphia, Lippincott, 1965.

Association for Research in Nervous and Mental Disease.
Infections of the nervous system: proceedings of the association, December 4 and 5, 1964, New York. Baltimore, Williams & Wilkins, 1968.

Austin, Charles J.
Medlars, 1963-1967. Washington, U.S. Public Health Service, 1968.

Behrman, Samuel J.
Progress in infertility. Boston, Little, Brown, 1968.

Bray, William Edward.
Clinical laboratory methods. 7th ed. St. Louis, Mosby, 1968.

Cameron, Charles S.
The truth about cancer. New York, Collier Books, 1967.

Ciba Foundation.
Ciba Foundation colloquia on ageing. Boston, Little, Brown, 1955.

Conference on Renal Function.
Transactions. 4th, 1952. New York, Josiah Macy, Jr. Foundation, 1952.

Cryosurgery. Springfield, Ill., C. C. Thomas, 1968.

Directory of suppliers of services, independent laboratories.
Health insurance for the aged. 1st ed.; October 1967. Washington, U.S. Social Security Administration, 1967.

Duncan, Garfield George.
A modern Pilgrim's progress with further revelations for diabetics. Philadelphia, Saunders, 1967.

Duvall, Evelyn Ruth.
About sex and growing up. New York, Association Press, 1968.

Grove, Robert D.
Vital statistics rates in the United States, 1940-1960. Washington, U.S. Public Health Service. National Center for Health Statistics, 1968.

Guide to scientific instruments, 1968/69. Washington, American Association for the Advancement of Science, 1969.

Harrison, Tinsley Randolph.
Principles and problems of ischemic heart disease. Chicago, Year Book Medical Publishers, 1968.

Heuser, Robert L.
Multiple births: United States, 1964. Washington, U.S. Department of Health, Education, and Welfare, Public Health Service, 1967.

Hospital Council of Maryland, Inc.
Directory of Maryland Hospitals. Baltimore, The Council, 1969.

International Congress of Neuro-genetics and Neuro-ophthalmology, 2nd, Montreal, 1967.
Abstracts of papers presented. Amsterdam, Excerpta Medica, 1967.

International directory of psychologists, exclusive of the U.S.A. Assen, the Netherlands, Royal Vangorcum, 1966.

Investigation of hypothalamic-pituitary-adrenal function: proceedings of a symposium sponsored jointly for Ciba Horsham, the Society for Endocrinology and the Endocrine Section of the Royal Society of Medicine. London, Cambridge U.P., 1968.

Jones, Peter G.
Torticollis in infancy and childhood. Springfield, Ill., Thomas, 1968.

Lederle Laboratories.
Aristocort (triamcinolone Lederle); a guide to therapy. Pearl River, N.Y., 1958.

Ocular therapy complications and management. St. Louis, Mosby, 1968.

L'Institut Bunge et La Fondation Born-Bunge.
Travaux deL'Institut Bunge et de la Fondation Born-Bunge. Anvers, 1967.

McKusick, Victor A.
Medelian inheritance in man. 2nd ed. Baltimore, Johns Hopkins Press, 1968.

McQuillan, Florence L.
Fundamentals of nursing home administration. Philadelphia, Saunders, 1967.

Massey, James T.
Suicide in the United States, 1950-1964. Washington, U.S. Public Health Service, 1967.

Merck, Sharp and Dohme.
Cardiac auscultation (recordings). West Point, Pa., Merck, Sharp and Dohme, 1967.

Michigan. University. Conference on Aging, 1948.
Living through the older years. Ann Arbor, University of Michigan Press, 1949.

Netherlands Association of Librarians.
Libraries and documentation centres in the Netherlands. The Hague, Netherlands Association of Librarians, 1967.

New Orleans Academy of Ophthalmology.
Symposium on surgical and medical management of congenital anomalies of the eye; transactions. St. Louis, Mosby, 1968.

Ophthalmological Societies of the United Kingdom.
Transactions, 1968, v. 88.

Peter Bent Brigham Symposium, Boston, 1967.
Diuretics in clinical medicine. Amsterdam, Excerpta Medica Foundation, 1968.

Progress in neurological surgery, v. 2, 1968.
Chicago, Year Book Medical Publishers, 1968.

Rossman, Isadore J.
The family handbook of home nursing and medical care. 2nd ed., rev. Philadelphia, Lippincott, 1968.

St. Barnabas symposium on surgical therapy of extrapyramidal disorders. New York, St. Barnabas Hospital and the New York University-Bellevue Medical Center, 1956.

Senn, Milton J. E.
The firstborn; experiences of eight American families. Cambridge, Harvard University Press, 1968.

Sheedy, Charlotte Baum.
Cooking for your celiac child. New York, Dial Press, 1969.

Simmons, Arthur.
Technical hematology. Philadelphia, Lippincott, 1968.

Steinmetz, Urban G.
Let's talk about sex. Notre Dame, Ind., Fides Publishers, 1968.

Union catalog of medical periodicals. New York, Medical Library Center of New York, 1968.

United Mine Workers of America Welfare and Retirement Fund. Report. Washington, 1967.

U.S. Advisory Committee on Obstetrics and Gynecology.
Report on intrauterine contraceptive devices. Washington, 1968.

U.S. Bureau of the Census.
Statistical abstract of the United States. 88th ed., Washington, 1967.

U.S. Government organization manual. Washington, 1967.

U.S. National Institutes of Health.
Scientific directory and annual bibliography. Washington, 1969.

U.S. Public Health Service.
Guidelines for coronary care units. Washington, U.S. Public Health Service, 1968.

U.S. Public Health Service. Division of Health Mobilization.
Hospital planning for national disaster. Washington, U.S. Public Health Service, 1968.

U.S. Public Health Service. Division of Health Mobilization.
The packaged disaster hospital; improved mass casualty care. Washington, U.S. Public Health Service, 1967.

U.S. Public Health Service. U.S. National Clearing House for Mental Health Information.
Publications resulting from National Institute of Mental Health research grants, 1947-1961. Chevy Chase, U.S. Public Health Service, 1968.

University of Virginia. Medical Center.
Serial holdings. Charlottesville, University of Virginia, 1968.

Van Westering, W. ed.
Cancer of the Breast; one year of international literature—1967. Amsterdam, Excerpta Medica, 1969.

Varga, Charles.
Handbook of pediatric medical emergencies. 4th ed. St. Louis, Mosby, 1968.

Weller, Charles.
The new way to live with diabetes; a complete guide. Garden City, N.Y., Doubleday, 1966.

Who's who in the East and Eastern Canada. Chicago, Marquis-Who's Who, 1968/69.

Yearbook of dentistry, 1969. Chicago, Year Book Medical Publishers, 1969.

Yearbook of the ear, nose & throat and maxillofacial surgery, 1969. Chicago, Year Book Publishers, 1969.

Yearbook of ophthalmology, 1969. Chicago, Year Book Publishers, 1969.

Yearbook of radiology, 1969. Chicago, Year Book Publishers, 1969.

Yearbook of urology, 1969. Chicago, Year Book Publishers, 1969.

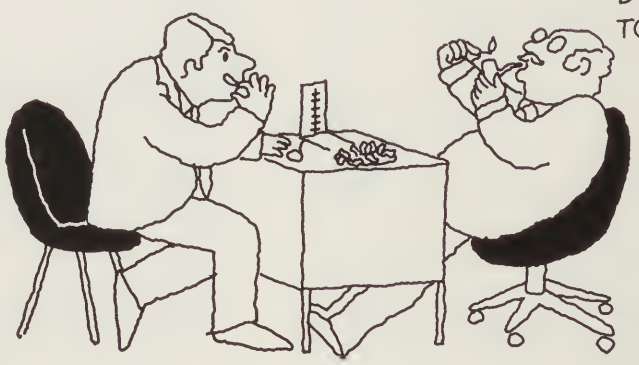
Zabarenko, Lucy.
Primary medical practice; a psychiatric evaluation. St. Louis, W. H. Green, 1968.

COLOSTOMY
ILEOSTOMY
Appliances and Disposable Bags
CALL
FIELDS PHARMACY
IN PIKESVILLE
for convalescent supplies and service
FOR RAPID DELIVERY 486-3300

BALTIMORE OXYGEN SUPPLY CO., INC.
OHIO CHEMICAL DISTRIBUTORS
Therapy and Medical Gases
and Oxygen Tents
Resuscitators and Apparatus
Main Office & Plant: Linthicum, Md. 789-8100
Warehouse: 1611 Guilford Ave., Baltimore, Md. 727-4748
Branch: 2426 Linden Lane, Silver Spring, Md. 582-2094

The Apprehensive Hypertensive



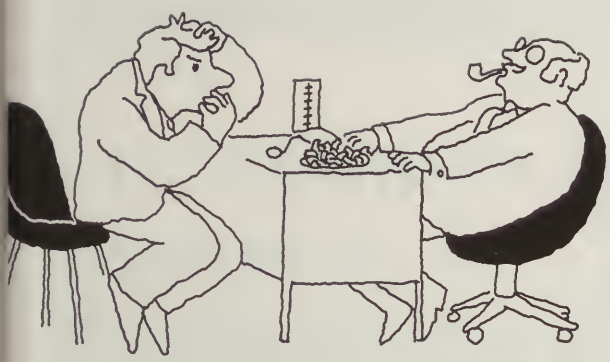


Regroton® to lower blood pressure

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increase respiratory secretions, nasal congestion, cyanosis and anorexia ma occur in infants born to reserpine-treated mothers. *Precautions:* Antih pertensive therapy with this drug should always be initiated cautious in postsympathectomy patients and in patients receiving ganglion blocking agents, other potent antihypertensive drugs, or curare. Reduc dosage of concomitant antihypertensive agents by at least one-half. T avoid hypotension during surgery, discontinue therapy with this ager two weeks prior to elective surgical procedures. In emergency surger use, if needed, anticholinergic or adrenergic drugs or other supportiv measures as indicated. Because of the possibility of progression renal damage, periodic kidney function tests are indicated. Discontinu if the BUN rises or liver dysfunction is aggravated. Hepatic coma ma be precipitated. Electrolyte imbalance, sodium and/or potassium de pletion may occur. If potassium depletion should occur during therap the drug should be discontinued and potassium supplements giver provided the patient does not have marked oliguria. Take particular car in cirrhosis or severe ischemic heart disease and in patients receivin

WE'VE GOT TO GET PLENTY OF REST AND TRY TO AVOID SITUATIONS THAT MAKE US ANXIOUS OR TENSE. AND WE'LL TAKE MEDICINE TO LOWER OUR BLOOD PRESSURE AND CALM US DOWN.





;nd allay anxiety in hypertension

c.icosteroids, ACTH, or digitalis. Severe salt restriction is not recom-
rnded. Use cautiously in patients with ulcerative colitis or gallstones
(iary colic may be precipitated). Bronchial asthma may occur in
sceptible patients. *Adverse Reactions:* The drug is generally well
trated. The most frequent side effects are nausea, gastric irritation,
viiting, diarrhea, constipation, muscle cramps, headache, dizziness
a acute gout. Other potential side effects include angina pectoris,
aiety, depression, bradycardia and ectopic cardiac rhythms (espe-
cly when used with digitalis), drowsiness, dull sensorium, hypergly-
cnia and glycosuria, hyperuricemia, lassitude, restlessness, transient
nopia, impotence or dysuria, orthostatic hypotension which may be
pentiated when chlorthalidone is combined with alcohol, barbiturates
narcotics, leukopenia, aplastic anemia, skin rashes, thrombocyto-
pia, agranulocytosis, nasal stuffiness, increased gastric secretions,
ntmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic
aophy and glaucoma, and pruritus. Eruptions and/or flushing of the
sn, a reversible paralysis agitans-like syndrome, blurred vision, con-
jctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King

KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

PROFESSIONAL LEASING
Special low rates for our medical customers. Call or stop in.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL
5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE
EVANGELICAL PRESS

THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected for possible growth of principal and income.

NO SALES CHARGE
NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

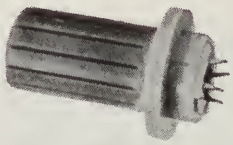
T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.



From the Subcommittee
on Traffic Safety of
the Medical and Chirurgical
Faculty of the
State of Maryland

Man Against Machine: International Accident Symposium

SUSAN P. BAKER, MPH
Research Associate, Division of Forensic Pathology
The Johns Hopkins School of Hygiene and Public Health

The Third Triennial Congress of the International Association for Accident and Traffic Medicine was held in New York from May 29-June 1. World-wide representation and a wide variety of topics added to the interest of the meeting.

John D. States and Ralph Sweetland, from the University of Rochester Medical School, described the extremely high risk of injury in rollover crashes. Forty percent of the occupants of cars which rolled over in highway mishaps were hospitalized or killed, compared to about 20% of the racing drivers whose cars rolled over. Since the average speed at the time of rollover was much greater for the racing cars (93 mph compared to 66 mph), the reason for the greater safety of their drivers was investigated.

The authors concluded that the use of restraint systems was the single most effective means of protection in rollovers; all 47 racing drivers were wearing lapbelts, and nearly half wore shoulder harnesses as well. Only 7 of the 41 persons in highway rollovers wore lapbelts; the most serious injury sustained by any of the seven was an acromioclavicular separation. Of 14 ejected persons, 2 were killed and the remainder hospitalized. Occupants were ejected from four out of five convertibles which rolled over in highway accidents. (The fifth involved an unusual type of restraint—seven people were packed so tightly into an Austin Healey that ejection could not occur.) Preservation of occupant space was also found to be important and was achieved in the racing cars by rollbars.

Kenneth G. Jamieson, from the Royal Brisbane Hospital, reported a study of 1000 consecutive victims who were killed or hospitalized in Brisbane, Australia. There were 188 deaths, about half of which occurred before the victims reached the hospital. Asphyxia and hemmorhage were the greatest problems in ambulance and emergency treatment. Head injury was of major concern because it was the most common injury and most often fatal, as well as producing the most protracted morbidity.

Volkswagens were involved in twice as many collisions with either cars or pedestrians, as would have been expected on the basis of vehicle registrations. Oversteering characteristics of the vehicle were evidenced by the injury patterns of Volkswagen occupants. The drivers sustained a low incidence of chest injuries, apparently because lateral spin before impact caused a sideways collision.

Medical examinations for drivers were considered to be contraindicated by the finding that only six of the collisions were associated with acute medical conditions, and only three of these could have been predicted by prior examinations. One fourth of all drivers who caused crashes, to which an ambulance was called, had criminal records. The irresponsible drivers, social deviates, and potential alcoholics who were

found in large numbers among those responsible for major collisions were believed to be unaffected by most deterrent measures. Recent alcohol legislation in Brisbane has apparently had its main effect on the somewhat more responsible drivers whose collisions are less likely to prove fatal.

Julian A. Waller, of the University of Vermont College of Medicine, gave further evidence of the association between violence and poor driving records. Persons involved in shooting accidents were far more likely to have had crashes, received citations for serious driving offenses, and had their licenses suspended than were a control group of drivers. Of those who had accidentally shot themselves or someone else, 32% had police records for actions involving intentional violence and 21% for alcohol abuse. The study suggests that "in specific situations, perhaps commonly involving alcohol, poor control of aggressive tendencies results in intentional acts of violence and in unintentional injury both on the highway and elsewhere."

One of the major implications of these papers is that prevention of serious and fatal highway injuries is more likely to be achieved by separating the occupant from inhospitable surfaces and reducing the energy exchanges involved, than by attempting to influence the irresponsible drivers who play a leading role in the most violent crashes.

DO YOU NEED



If you are a doctor or dentist or supervise a staff in a hospital or nursing home, there are times when you have wished that help was a phone call away. Now it is. Call us night or day for the nursing or medical office employees you need. Our service is national, our employees are experienced, screened, insured and bonded.

MEDICAL PERSONNEL POOL
Washington—Phone 667-6345
Baltimore—Phone 685-5053



SLEEP ZONE

To turn a hospital zone into a sleep zone, you need more than peace and quiet. Your patients need a mattress which gives the right kind of firm, comfortable support. To hospitals across the country, this means the Serta Perfect Sleeper "Hospital" mattress.

It provides restful, healthful sleep, because the patient sleeps **on** it, not in it. And just as important to you, the Serta Perfect Sleeper retains its firmness for years and years of service.

Interested? There's a Serta contract bedding expert near you. Let him help you choose from the comprehensive range of specifications on Serta quality bedding.

SERTA

CONTRACT DEPARTMENT
8415 Ardmore Road
Landover, Md.
322-1000
BALTIMORE—PL 2-2087

Words to go to sleep by
PERFECT SLEEPER MATTRESS
Serta

Dulcolax®...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



CENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS, DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU-6681

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND

OBESITY WAS A MILITARY OFFENSE!

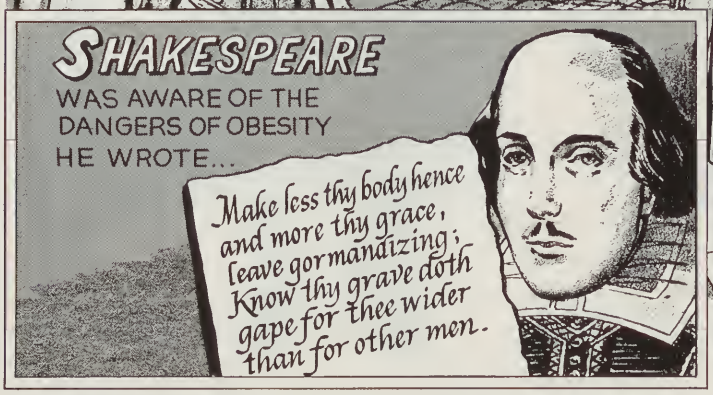
OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!

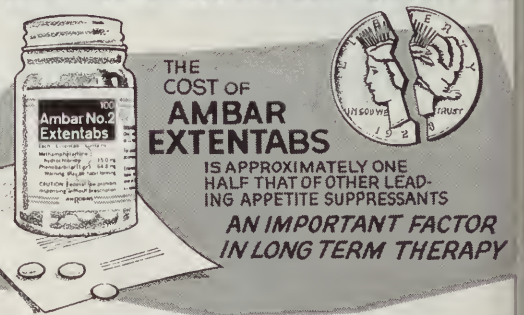


RECORDED ON AN ENGLISHMAN'S TOMBSTONE

SHAKESPEARE

WAS AWARE OF THE DANGERS OF OBESITY HE WROTE...





CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOS

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Amba suppresses appetite and helps offset emo tional reactions to dieting. **Contraindic tions:** Hypersensitivity to barbiturates c sympathomimetics; patients with advance renal or hepatic disease. **Precautions:** Administer with cau tion in the presence of cardiovascular disease or hypertensio **Side Effects:** Nervousness or excitement occasionally note but usually infrequent at recommended dosages. Slight drow iness has been reported rarely. See package insert for furth details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A-H-ROBIN

ABBEY RENTS
SICKROOM EQUIPMENT

Prompt, professional service 24 hours a day, every day! A complete line of hospital beds, wheelchairs, traction equipment, oxygen, crutches, walkers, commodes, lamps, whirlpools—everything to help patients get well faster.

We Process MEDICARE Equipment Claims.

358-3400
6316 Reisterstown Road
Baltimore

Disaster Training

The American College of Surgeons, in a resolution adopted by the Board of Regents, has stressed its support of programs relating to the training in disaster medicine. The college expressed its opinion on this matter because federal support for the Medical Education for National Defense (MEND) program has been eliminated from the current federal budget.

MEND was initiated in 1952 by the Department of Defense as a pilot project which provided funds to five medical schools for the development of informal programs of medical education for national defense. By 1965, 89 medical schools were participating in the program.

The resolution, which was sent to federal agencies responsible for the administration of the program, reads as follows:

"RESOLVED, that the Board of Regents of the American College of Surgeons support programs of appropriate training of medical students, interns, residents and doctors in practice in the practice of medicine and surgery under adverse emergency conditions, such as may occur in a military or civil disaster situation."

DOCTORS' OFFICES

LARGE
MEDIUM
SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST. CORPORATION

11 E. Chase St.
Phone 539-8553

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION
ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE
DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily
Tuesday Evenings 7 to 9

355-9300
PATAPSCO AVENUE & FOURTH STREET
Baltimore, Maryland, 21225



Last year BLUE SHIELD® paid $20 million in doctor bills for its members

Blue Shield membership is a genuine bargain: Ninety cents out of every dollar paid in by members is *paid back* in the form of receipted doctor bills. No wonder more than one million Marylanders protect themselves against unexpected medical-surgical expenses by belonging to Blue Shield. No wonder 300 of the nation's 500 largest corporations carry Blue Shield for their employees.

The unselfish devotion of Maryland doctors who serve as Blue Shield board and committee members without remuneration is a very important contributing factor to Blue Shield's low administrative expenses.

To find out more about Blue Shield, just use the coupon.

Maryland Blue Shield®

7800 York Road
Baltimore, Maryland 21203

Please send me my free copy of your booklet on Blue Shield.

Name_____

Address_____

City_____ State_____ Zip_____

The "Monday Syndrome": A Reality

Are you suffering from "Monday syndrome"?

There may be such a thing, reports the Health Insurance Institute.

A study of 500 workmen's compensation reports from the files of a large insurance company suggests the possibility.

This syndrome is now being used to explain what you may have realized—that Monday is the worst day in the week to return to work after an illness, accident or vacation.

There appears to be some relationship between Monday being the first day back and a higher incidence of accidents, lower production and increased cost of production.

As a consequence, this insurance company is advising physicians to reconsider prescribing Mondays as back-to-work days for patients recovering from illnesses and injuries.

The insurance company also noted that 54% of all injured workers in its study return to work on Monday.

According to a spokesman for the insurance company:

"Plenty of physicians, if they thought about it, would actually prefer to have the patient go back to work on a Thursday or Friday after a period of incapacity and have the advantage of a weekend's rest before barging into a full week."



For elderly patients in need of a mild tranquilizer consider **Tybatran®**

brand of tybamate

(When you consult the Prescribing Information you may agree it makes good sense)



PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

Less Than a Penny for Drugs?

Of each dollar of disposable income, the average American spends less than one penny for prescription drugs!

The average American spends less than one-fifth as much for life-saving, health-giving drugs as he does for recreation or for liquor and tobacco.

BERNHARDT E. CLARA E.
PIELKE
LANDSCAPE SERVICE



Give your home new beauty with
SKILLFUL LANDSCAPING
TREES, PLANTS, SHRUBBERY
expertly planned and planted
FREE ESTIMATES
BELTWAY GARDEN CENTER
7937 Belair Road, Baltimore Md. 21236 NO 8-3965

Baltimore's most unusual dining place!
Famous
Owl Room



Belvedere Hotel
Charles & Chase Streets

MANUEL SCHWARTZ
HEARING REHABILITATION
321 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201
DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION
Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

STERLING
LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY
We Repair and make Lamps
"Lamps make the home Beautiful"
LE 9-0222 403 N. Charles Street
Baltimore, Md. 21201

MERCEDES-BENZ
Baltimore's only Authorized Dealer for Sales, Service and Parts
R. & H. Motors, Inc.
4810 Belair Rd. 426-9200
Baltimore, Md. 21206

WE PRESCRIBE FOR DOCTORS:
Invest your money where it will earn a high return in complete safety
CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000



WHEN YOUR PATIENTS NEED
NURSING CARE
Call Milton 4-6060
Alice Weber
Baltimore Nurses Exchange
LICENSED & BONDED
24 HOUR SERVICE ESTABLISHED 1935
BALTIMORE, MARYLAND 21229



For the "Cheater Eater"

Formulas: Each 'Dexamyl' *Spansule* capsule No. 1 contains 10 mg. of Dexedrine® (brand of dextroamphetamine sulfate) and 1 gr. of amobarbital, derivative of barbituric acid (Warning, may be habit forming). Each 'Dexamyl' *Spansule* capsule No. 2 contains 15 mg. of Dexedrine (brand of dextroamphetamine sulfate) and 1½ gr. of amobarbital (Warning, may be habit forming).
Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.
Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.
Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.
Supplied: In bottles of 50.

Dexamyl®

brand of dextroamphetamine sulfate and amobarbital

Spansule®

brand of sustained release capsules

curbs appetite
encourages normal activity
dispels diet discouragement

SK&F
Smith Kline & French Laboratories

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ INGLESIDE SHOPPING CENTER
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ HILLENDALE SHOPPING CENTER
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our *2 All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.



Traditional Japanese Cuisine

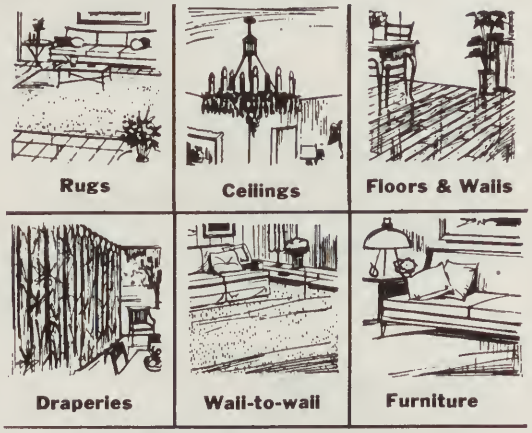
SUKIYAKI TEMPURA
TERIYAKI SUSHI
. . . and others

COCKTAILS AND MIXED DRINKS
SAKE (RICE WINE)
JAPANESE BEER—ASAHI AND KIRIN

11 A.M.—11 P.M.
CLOSED MONDAY

SAKURA PALACE

7926 Georgia Ave., Silver Spring, Md. 20900
JU 7-7070



TRUST CHESAPEAKE

To Clean Them All!

*Service*MASTER specifications for carpet and furniture cleaning are recommended by leading carpet mills and furniture manufacturers nationwide. TRUST CHESAPEAKE for expert cleaning of office wall-to-wall carpeting, rugs, furniture, draperies, ceilings, floors, walls. **488-3000**

CHESAPEAKE
Rug & Drapery Cleaners

This is the new 144S Volvo Sedan For 1969



What a prescription for "Same-old-car-itis."

Volvo offers the most advanced safety features of any car. It's so economical it gets up to 25 m.p.g. With automatic transmission, stereo tape, air conditioning available—and world famous Volvo quality built-in, we think you'll agree the prognosis is extremely favorable.

FREE 24 HOUR DEMONSTRATION

michaelson
motors, inc.

America's Largest Volvo Dealer
5801 REISTERSTOWN RD.
Open Nitely 'til 9:30 • 358-5800

SKIN PROBLEMS

Caused by itching due to:

Dry Eczema	Acne
Chafing	Ivy Poisoning
Minor Burns	Cold Sores
Athlete's Foot	Heat Rash
Dry Skin	Diaper Rash
Wind Burn	Chapping
Insect Stings	Hemorrhoids

For Safe, Sure, Speedy Relief —
— Get RESINOL GREASELESS!

Medical Scientists have conquered 6 dread diseases in the past decade, but they are largely in the dark, they admit, in finding relief for one age-old ailment—itching



New remedies containing antibiotics have been tested, but have often caused side effects which are worse than itching skin. After many years of research and testing, Resinol Greaseless Cream was developed. . . . A doctor's formula containing safe yet powerful ingredients, Resinol Greaseless contains an amazing, proven "anti-itch" medication called Resorcin, which quickly and effectively relieves most any kind of itching. Try Resinol Greaseless . . . You'll be delighted to find that it really works! At all drug stores. Buy a tube today.

Family First Aid in a Tube
Carry in Purse or Pocket
A Medicine Cabinet "Must"

"Resinol Really Works"

RESINOL CHEMICAL COMPANY
517 W. Lombard St.
Baltimore, Md. 21201

"Survey of Hospital Charges..." Offered

The Health Insurance Council has announced publication of "Survey of Hospital Charges as of December 1968," an itemized breakdown of hospital expenses throughout the nation.

The book details costs—including X-ray, drug and laboratory—in terms of average hospital charges. It divides the United States into census division, state, and standard metropolitan statistical areas including the nation's 25 largest counties.

The national survey also reports on charges for intensive care and extended care units as well as average daily service charges in both voluntary and proprietary hospitals.

It was prepared by the American Hospital Association for the Council.

To obtain a copy, write to William W. Reinertson, Health Insurance Council, 750 Third Avenue, New York, N.Y. 10017.

The price is $10 for the first copy and $5 for each additional copy.



For the Best in Leisure Living
Enjoy a vacation at the

Atlantic Sands
MOTEL
Boardwalk and Baltimore Ave.
REHOBOTH BEACH, DELAWARE

- 80 FINE ROOMS
- AIR CONDITIONED
- TELEVISION
- BEACH SHOP
- HEATED POOL
- TELEPHONE SERVICE
- RESTAURANT
- ELEVATOR SERVICE

OPEN ALL YEAR LONG!
Write for Reservations . . . . . or
Phone **(302) 227-2511**

NOW
A NEW CONCEPT
in
BOOKEEPING
and
TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

SECURITY BUSINESS SERVICES, INC.

Box 335
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager

Women Drivers Hav

Perhaps the oldest joke in 20th-century America is the woman driver put-on, according to The Travelers Insurance Companies annual booklet on highway accident statistics.

Of the 68,000 drivers involved in fatal accidents in 1968, only 10,000 were women.

However, a spokesman notes that "the big gun in this battle of the sexes is the canard that women are emotionally incapable of handling a car in an emergency. Or that an ignorance of anything mechanical makes it impossible for them to understand how to drive safely.

"Some women *do* get rattled easily," the spokesman concedes. "Some women *are* bewildered by

HOOD CONVALESCENT HOME

"Typifies The Highest Standards Now Available"



COMPLETE FACILITIES FOR THE PROPER CARE OF

CONVALESCENTS, CHRONICS, INVALIDS, POST OPERATIVES

PHYSICIANS EXTENDED EVERY COURTESY
INSPECTION INVITED

National Association of Registered Nursing Homes, Inc.
PROTECTED BY MODERN SPRINKLING SYSTEM

Certificate Holder—Baltimore County
Fire Prevention Bureau Award

LICENSED BY MARYLAND STATE BOARD OF HEALTH

947-2800

5313 EDMONDSON AVE.

ewer Accidents

nuts and bolts. And precisely the same can be said for some men," he added.

Statistics in the booklet prove many reasons why cars crash: speed too fast for conditions; driving on the wrong side of the road; did not have the right of way; cutting into a line of traffic; passing on curve or hill; passing on wrong side; failure to signal and improper signaling; reckless driving, etc. Sex of the driver is not a proven reason.

"The fact is," the spokesman said, "there are many more male drivers who drive many more miles than the average female. Until we have figures indicating the number of miles driven by male vs. female, the woman-driver joke will remain no more than a put-on."

For your next meeting, banquet or convention . . . consider



THE NEW OCEAN CITY
CONVENTION HALL

One of the most beautiful facilities on the east coast—ideal for sales meetings, private parties, banquets, conventions, trade shows . . . concerts, dances and sporting events. Will accommodate up to 2000 at a banquet, 3000 at a convention; meeting rooms for 50 to 300 persons. Air-conditioned and heated—for year-round use. Large private parking area.

For complete information . . . . write
EARL G. BAIRD, *Executive Director*
4000 Philadelphia Ave., Ocean City, Md. 21842

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

Geo. **RADEBAUGH**
& Sons

120 Burke Ave. Towson, Maryland 21204
Phone VAlley 5-4300

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545

D S

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL **MED-ICAL**
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.

Miss Gladys Deeds
Manager

213 West Saratoga St. 727-7011

OPEN DAILY THROUGH LABOR DAY!

Breakfast—Luncheon—Dinner

Credit Cards Honored



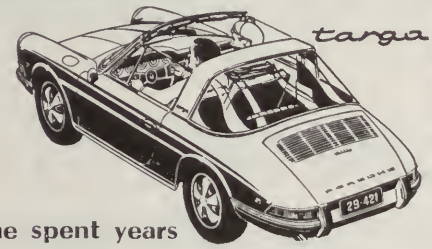
2 Christian St., Rehoboth Beach Delaware

Phone Area Code: 302-227-2561

Blanche Thompson at the Electric Organ

VISIT OUR UNIQUE GIFT SHOP

PORSCHE



Porsche spent years developing a great competition car so you could have fun driving to work.



Both body styles available in four engines:
912 - 911T
911E - 911S

Sportomatic available on 911 series only

40 West VOLKSWAGEN

Phone: 744-2300

6624 Baltimore National Pike
West of Beltway Exit 15 on Rt. 40 West

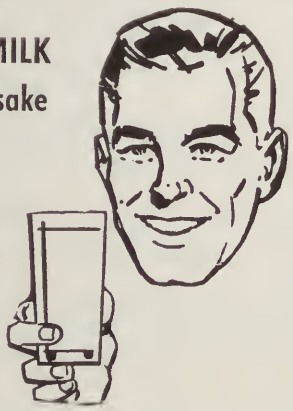
A Simple Cure

There's a new organization called Marriage Anonymous. Any time a bachelor feels like taking the fatal steps, he calls M.A. and they send over a woman in housecoat and curlers . . .



MITCHELL'S
MARYLAND
CORN!
Garden Flavor Guarded
F. O. Mitchell & Bro., Inc.
Perryman, Maryland
Phone Perryman 272-3636
Plant Phone
Perryman 272-3637

DRINK MORE MILK
for your health sake



- More Vitamins
- More Minerals
- More Energy



Deliveries in Maryland, Washington and Virginia.

Looks Delicious, Tastes Beautiful.

EMBASSY DAIRY
DU 7-1441
1620 First St. N.W.
Washington, D.C.

Brentwood Inn

FRENCH CONTINENTAL CUISINE

Smorgasbord Luncheon and Dinner
every Tuesday . . . . .

"Home of Maryland's Internationally Famous Wine Cellar" . . . .

We honor all preferred Credit Cards



● *NEW!* Another Dining Room has been added to accommodate our many guests ●

OPEN DAILY & SUNDAY 11 A.M. to 2 A.M.

Fifth Ave. & Brentwood—1 block N. E. of Dundalk and Holabird Ave. 1 mile from Holabird Ave. Exit of Baltimore Harbor Tunnel

We cater to Private Parties, Banquets and Dinners

AT. 5-0520 *Ample Free Parking* **BALTIMORE, MD. 21222**

OFFICERS OF
THE MEDICAL AND CHIRURGICAL FACULTY

President: Russell S. Fisher, MD
President-Elect: Henry A. Briele, MD
First Vice President: Marvin I. Mones, MD
Second Vice President: Samuel Morrison, MD
Third Vice President: Guy M. Reeser, MD
Secretary: William A. Pillsbury, MD
Treasurer: Karl F. Mech, MD

COUNCILORS

Western District

Richard Y. Dalrymple, MD—1972
Robert J. Thomas, MD—1972

Central District

William Carl Ebeling, MD—1970
John Collins Harvey, MD—1970
John F. Schaefer, MD—1970
William G. Speed, III, MD—1970
J. Arthur Weinberg, MD—1970
John T. Chissell, MD.—1971
John M. Dennis, MD—1971
J. Morris Reese, MD—1971
Harry M. Robinson, Jr., MD—1971
Donald J. Roop, MD—1971
Robert C. Kimberly; MD—1972

Eastern District

Arthur T. Keefe, MD—1970
Raymond M. Yow, MD—1971

Southern District

J. Parran Jarboe, MD—1971
Manning W. Alden, MD—1972

South Central District

Henry P. Laughlin, MD—1970
John G. Ball, MD—1971
Wolcott L. Etienne, MD—1971
Seruch T. Kimble, MD—1971
William B. Hagan, MD—1972

Terms of office expire at conclusion of annual meeting

DELEGATES TO THE
AMERICAN MEDICAL ASSOCIATION

Russell S. Fisher, MD—1969
J. Sheldon Eastland, MD—1970
Robert vL. Campbell, MD—1971

ALTERNATES:

M. McKendree Boyer, MD—1969
Robert C. Kimberly—1970
Charles F. O'Donnell, MD—1971

Terms of office expire at end of calendar year

Have you noticed *how quickly the bumper stickers for losers in the last election are removed . . . and how long the winners stay on.*

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery MU 5-3232

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202

Do Your Patients Need Nursing Service?
Call **889-5666**
COBB-WOODS SERVICES
Vera Woods, M. A. Director
2213 St. Paul St. Baltimore, Md. 21218
Licensed by the State of Md.

SKILL SURGICAL, INC.
SKILL
SUPPLIES & EQUIPMENT
for
PHYSICIANS—SURGEONS
HOSPITALS
5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

The MEDICAL and CHIRURGICAL FACULTY
of the State of Maryland

ACCIDENT AND HEALTH PROGRAM FOR FACULTY MEMBERS

- **ACCIDENT AND SICKNESS TOTAL DISABILITY**
- **MAJOR MEDICAL EXPENSE**
- **ACCIDENTAL DEATH AND DISMEMBERMENT**

Administered by
THE MED-CHI INSURANCE TRUST

Official Faculty Agent
B. Dixon Evander and Associates

Underwritten by
Hartford Accident and Indemnity Company

Member of
The Hartford Insurance Group
Hartford, Connecticut

For more information detach and mail slip directly to:

MED-CHI INSURANCE TRUST
1211 Cathedral Street, Baltimore, Maryland 21201

*Name*_____

*Address*_____

*City and State*_____ *Zip Code*_____

Classified Advertising

POSITIONS AVAILABLE

GENERAL SURGEON—For 1150-bed Psychiatric Hospital with 150 beds active General Medical Service and 15 Surgical beds. Research facilities available. Primary responsibility: diagnosis, consultation, and emergency procedures. All major surgical procedures performed at another VA hospital. Salary $18,531-$28,069 depending upon qualifications. Upper Chesapeake Bay area, station housing at reasonable rental, golfing, fishing, and boating facilities available. Contact: Chief of Staff, Veterans Administration Hospital, Perry Point, Md. 21902. Tele. No. (301) 642-2411, ext. 253. An Equal Employment Opportunity Employer.

INTERNISTS—(General Medicine) for a 765-bed GM&S hospital and 550-bed Domiciliary; affiliated with George Washington Univ.; low-cost housing and excellent receational facilities available; within easy driving distance of Washington, D.C. and Baltimore, Md. An equal opportunity employer. Apply: Chief of Staff, VA Center, Martinsburg, West Virginia 25401.

PARTNERSHIP, GP—Modern two-doctor office building; well-equipped. Good country; congenial people. Baltimore-Washington area. Salary or percentage first year. Retiring in 2-3 years. Open staff hospitals available. Adequate time off. Details appreciated in reply. Write: Box #16, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

FOR SALE

NEW RECORD-O-FONE ANSWERING SERVICE MACHINE—Originally sold for $640, asking $420. You can receive your message from anywhere, any time. Also has monitor. Call: 922-3092. (Randallstown).

ESTABLISHED MEDICAL PRACTICE INCLUDING BUILDING AND EQUIPMENT—Ideal for group. Reasonable—to settle estate. Call: 727-0033 (Baltimore).

BAR & EQUIPMENT—From the estate of Dr. Leon Freedom. Equipment includes: Executive desk with glass top, lab and swivel chair—$50; Welsh-Allen Otoscope; Shock therapy machine $100; medical and psychiatric books (some collector's items); 1 dozen electric razors; electric shoe-shiner $15. Call: 752-4203 (Balto.)

ANTIQUE—Patent Magneto Electric Machine for Nervous Diseases. Over 100 years old. In working condition. Best offer. Call: 752-4203 (Balto.)

FOR RENT

THREE-ROOM SUITE—Suitable for GP or other. 1st floor, private entrance. Located in private home of finished masonry block. Suite is 12 x 60' L-shaped. Waiting room, consultation room, 2 baths. Air-conditioned. Accessible to hospitals. Owner renting. Negotiable. Call: 889-8327 (Balto.).

SERVICE OFFERED

MEDICAL ABSTRACTING—From Microfilm. Research, technical writing, no typing. Call: (301) 433-7965, Mrs. Manley.

CLASSIFIED ADVERTISING

Effective September 1, 1969

$2.00 per line per insertion

Count seven average words to each line. Add one line if box number is desired.

Members of the Medical and Chirurgical Faculty shall be entitled to one complimentary insertion in any twelve-month period. Widows of members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment.

MARYLAND STATE MEDICAL JOURNAL

1211 Cathedral St., Baltimore, Md. 21201

Advertisers in This Issue

Abbey Rents 125
A & F Nurses Registry 105
Aids for Hearing, Inc. 136
Akehurst Nurseries 91
Arundel Federal Savings & Loan Asso. 125
Atlantic Sands Motel 133
Baltimore Nurses Exchange, Alice Weber 130
Baltimore Oxygen Supply Co., Inc. 117
Belvedere Hotel 130
Bolton Hill Dinner Theatre 20
Brentwood Inn 137
Bristol Laboratories 54
Broadview Restaurant 111
Burroughs Wellcome & Co. 95
Campbell Soup Co. 51
Capital Savings & Loan Asso. 130
Oscar Caplan & Sons 8
Chesapeake Farm, Inc. 35
Chesapeake Federal Savings & Loan Asso. 100
Chesapeake Rug and Drapery Cleaners 132
Club Venus 111
Cobb-Woods Services 138
Coca-Cola Bottling Co. 100
Cork 'n Bottle Restaurant 111
Dinner Bell Inn & Motel 136
Doctors Supply Co. 136
Dulaney Towson Nurs. & Conv. Home 32
Eastern Overall Co., Div. of Rentex .....2nd Cover
Eastern Research Laboratories .....3rd Cover
Eleven East Chase St. Corp. 125
Embassy Dairy 137
Eutaw Savings Bank 18
Evangelical Press 120
Fedder's Medical Services, Inc. 8
Federated Business Services, Inc. 134
Fields Pharmacy 117
Forty West Volkswagen 137
Franklin Uniform Co. 105
Geigy Pharmaceuticals 98-99, 118-119, 123
The Gundry Sanitarium 17
Hecht Co. Northwood Rooftop Restaurant 111
High Fidelity House 20
Highland Hospital 20
Hood Convalescent Home 134
House In the Pines Nursing Homes 40
Hynson, Westcott & Dunning, Inc. 1
Jobst Service Center 90
Key Circle Hospice 14
Koch Associates 112
Lederle Laboratories 2, 120, 127
Eli Lilly & Co. 12
Maico Hearing Aids, Inc. 136
Maria's 300 Restaurant 111
Maryland Blue Shield 126
Maryland National Bank 4
Maryland Psychiatric Research Center 112
McNeil Laboratories, Inc. 22
Medical Personnel Pool 122
Merck Sharp & Dohme 92-94
Michaelson Motors, Inc. 132
Miller Brothers Restaurant 111
Milton Inn 111
F. O. Mitchell & Bro., Inc. 137
Monarch Lincoln Mercury 120
Robert Morris Inn 100
Murray-Baumgartner Surg. Instr. Co., Inc. 11
National City Bank of Baltimore 91
National Drug Co. 15-16, 106
Ocean City Convention Hall 135
Palmer House Restaurant 111
Parke, Davis & Co. 21, 107
Peabody Institute 19
Chas. Pfizer & Co., Inc., Pfizer Laboratories Division, Bonine, Terramycin 24-25, 38-39
Pielke Landscape Services 130
T. Rowe Price Growth Stock Fund, Inc. 120
Professional Systems, Computer Center 11
Professional Associations Div., Insurance Management 55-58
Geo. Radebaugh & Sons 135
Read's Drug Stores 132
Resinol Chemical Co. 133
R & H Motors, Inc. 130
A. H. Robins Co. 26-31, 33-34, 124, 128-129
Roche Laboratories .....36-37, 96-97, 4th Cover
Sakura Palace 132
Sandoz Pharmaceuticals 108
Manuel Schwartz, Hearing Rehab. 130
G. D. Searle & Co. 52-53
Security House, Inc. 88
Security Savings & Loan 112
Serta Mattress Co. 122
Skill Surgical Instrument Co. 138
Smith, Kline & French Laboratories 131
Special Diet Shop 102
Sterling Lighting Co. 130
Strasenburgh Laboratories 23
Mano Swartz—Furs 8
Therapeutic Appliances, Inc. 19
Tijuana Tacos 111
Towson Valley Motors 102
D. Stuart Webb, Advertising Services, Inc. 138
Westview Lounge & Supper Club 111
Helaine White, Realtor 18
White Rice Inn 111
Wyeth Laboratories 113-114
Zimmermann's Shoes 8


SOC · MED · & CHIRURG · TERRÆ MARIÆ · SIGILL · MENSE · JUNII · A · D · 1799 & LIBERT · AMERIC · 23 to
INSTITUT ·
ΠΟΛΛΩΝ ΑΝΤΑΞΙΟΣ ΑΛΛΩΝ



after surgery...

To restore tissue depletion of Vitamin B Complex and ascorbic acid induced by the physiological stress of surgery, illness or injury—Increases the recuperative power of convalescence.

beta massive capsules

B COMPLEX WITH VITAMIN C



Thiamine HCl	B_1	10 mg.
Riboflavin	B_2	10 mg.
Pyridoxine HCl	B_6	5 mg.
Cyanocobalamin	B_{12}	4 mcg.
Ascorbic Acid	C	150 mg.
Calcium Pantothenate		20 mg.
Niacinamide		50 mg.

EASTERN RESEARCH LABORATORIES, INC.

302 S. CENTRAL AVE. BALTIMORE, MARYLAND 21202



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patient against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed again its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit t smallest effective dosage (initially 10 mg or less per day) to preclude ata or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiat drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Emp usual precautions in treatment of anxiety states with evidence of impend ing depression; suicidal tendencies may be present and protective measu necessary. Variable effects on blood coagulation have been reported ver rarely in patients receiving the drug and oral anticoagulants; causal rela tionship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especia in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the low dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstru irregularities, nausea and constipation, extrapyramidal symptoms, incre and decreased libido—all infrequent and generally controlled with dosa reduction; changes in EEG patterns (low-voltage fast activity) may appea during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, maki periodic blood counts and liver function tests advisable during protracted therapy.

MARYLAND
STATE MEDICAL JOURNAL
VOLUME 18 NUMBER 10
OCTOBER 1969

READING ROOM

READING ROOM

RECEIVED
NOV 1 2 1969
National Library of Medicine



NATIONAL LIBRARY OF
9600 ROCKVILLE PIKE
BETHESDA MD 20014

the right attitude:

The right attitude has earned us an enviable reputation in Baltimore's wide spectrum of health care establishments. We feel that our approach to the problems of the elderly, chronically ill, and convalescent patient makes us different.

Our *people* are not only doing a job but also giving of themselves beyond the call of duty to provide our guests with more than the average amount of service expected.

If the right attitude is what you're looking for . . . concerning a day & night vigil by professional nurses . . . individually programmed meals under the control of our staff dietician — physical, occupational, recreational therapy designed to reach a goal in the patient's care and well-being . . . a pleasant home-away-from-home atmosphere . . . Edgewood Nursing Home should be your first preference.

WATCH FOR OUR GRAND OPENING:

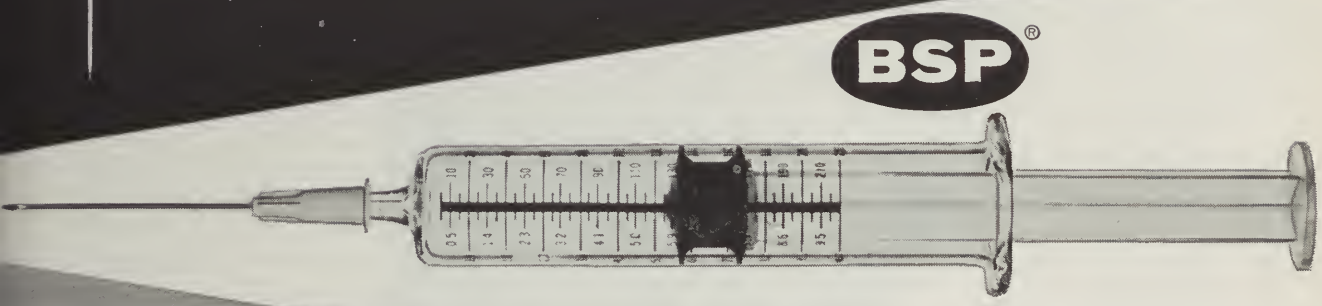
By the first of the year — our completely new 100 bed facility will be finished — we are Baltimore's most centrally located nursing home. Minutes from Towson. Roland Park, Homeland and all of Northern Baltimore's hospitals.

EDGEWOOD
NURSING & CONVALESCENT HOME
6000 Bellona Avenue, 323-4223

BSP® DISPOSABLE UNIT

HW&D BRAND OF SODIUM SULFOBROMOPHTHALEIN INJECTION, USP

(50 mg. per ml.)



BROMSULPHALEIN® IN A STERILE, DISPOSABLE, ECONOMICAL UNIT

The Bromsulphalein test is a convenient, sensitive, reliable test of liver function.

The precalibrated syringe contained in the BSP Disposable Unit makes weight calculations unnecessary, providing proper dosage regardless of patient-weight. Each unit contains complete directions for use, precautions and contraindications.

The all-inclusive BSP Disposable Unit provides economic unit dispensing.

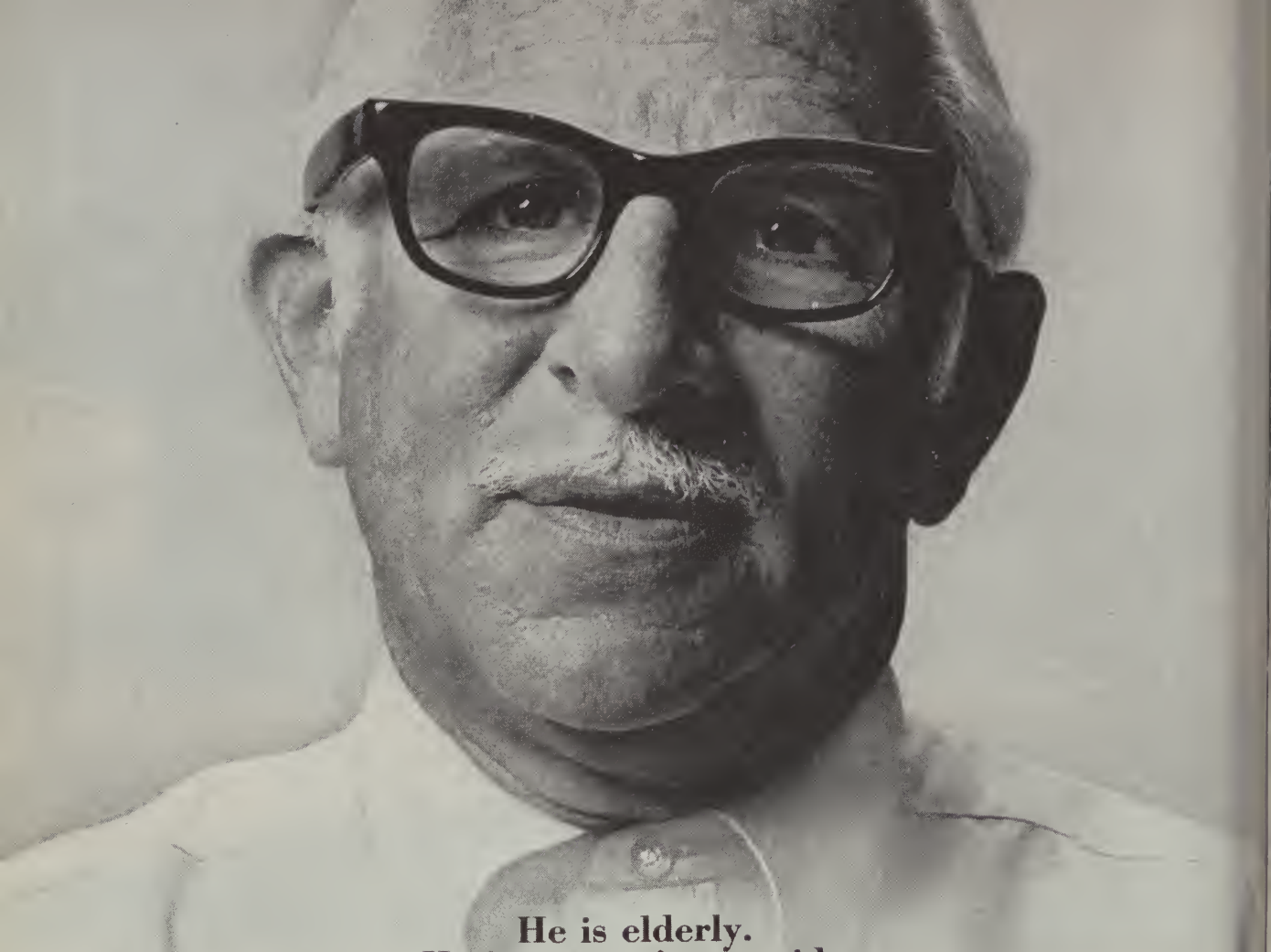
Complete literature available on request.

HYNSON, WESTCOTT & DUNNING, INC.

HW&D

Baltimore, Maryland 21201

(BSP04)



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300 b.i.d.

Demethylchlortetracycline HCl 300 mg
and Nystatin 500,000 units
CAPSULE-SHAPED TABLETS Lederle

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN —the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriat measures should be taken. In infants, increased intracranial pressur with bulging fontanels has been observed. All signs and symptoms hav disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, diar rhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopap ular and erythematous rashes; a rare case of exfoliative dermatitis ha been reported. Photosensitivity; onycholysis and discoloration of th nails (rare). Kidney—rise in BUN, apparently dose related. Transien increase in urinary output, sometimes accompanied by thirst (rare Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxi Teeth—dental staining (yellow-brown) in children of mothers given thi drug during the latter half of pregnancy, and in children given the dru during the neonatal period, infancy and early childhood. Enamel hypo plasia has been seen in a few children. If adverse reaction or idiosyn crasy occurs, discontinue medication and institute appropriate therap Demethylchlortetracycline may form a stable calcium complex in an bone-forming tissue with no serious harmful effects reported thus fa in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should b given 1 hour before or 2 hours after meals, since absorption is impaire by the concomitant administration of high calcium content drugs, food and some dairy products. Treatment of streptococcal infections shoul continue for 10 days, even though symptoms have subsided.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

345-B

Maryland State
Medical Journal

VOLUME 18 OCTOBER 1969 NUMBER 10

CONTENTS:

Death from Narcotics Use: Baltimore City, 1963 through 1968, Edward F. Wilson, MD, and Russell S. Fisher, MD 49

"Baltimore city, during 1968, experienced a staggering increase over past years in the number of deaths attributed directly to the use of narcotics. New York, Philadelphia, and Miami experienced similar increases. The purpose of this report is to document various parameters of Baltimore's increase."

Sacculotomy in the Treatment of Meniere's Disease, N. Edward Nachlas, MD, Mervin Trail, MD, and Donn Duncan, MD 53

"The treatment of Meniere's disease has long been a therapeutic enigma as testified to by the many and varied methods in use today. In this paper, the features of Meniere's disease will be discussed, with a recent surgical procedure reported that has yielded gratifying results in six patients."

Wound Disruption After Abdominal Laparotomies, Roberto O. Ferrer, MD 57

"The process of wound healing has a high biological priority. Most wounds heal completely within a relatively short period of time, in spite of preoperative starvation, infection, or increased force against their tensile strength. A few wounds do not heal, but disrupt. Many factors play a role in the disruption of a laparotomy wound: increased intra-abdominal pressure, metabolic state of the patient, wound infection, and surgical technique. . . . This paper is a comparison of the frequency of wound disruption after abdominal operations in St. Joseph Hospital with that reported in the literature, and an evaluation of the predisposing causes in an effort to present this complication."

Pulmonary Fibrosis Following Radiotherapy for Bronchogenic Carcinoma and Hodgkin's Disease, H. Gunter Seydel, MD, J. Maun, MD 61

"The incidence of moderate to severe pulmonary fibrosis following radiotherapy for mediastinal Hodgkin's disease was 68% in 21 patients. The corresponding incidence in 20 patients with bronchogenic carcinoma was 75%. Severe symptoms occurred in 10% of the patients with Hodgkin's disease one year after radiotherapy, while the incidence of severe symptoms among the patients with bronchogenic carcinoma was 30%. No patients died due to causes arising from the pulmonary fibrosis."

Emergency Room Problems of an "Inner Core" City Hospital, William E. Beaven, MD, Juan F. Sordo, MD, Patricia Wheltle, RN 63

"An in-depth analysis of the Emergency Department, Bon Secours Hospital."

DEPARTMENTS:

Traffic Safety—Highway Deaths, Natural and Traumatic, Susan P. Baker, MPH 45

Your Medical Faculty at Work, John Sargeant 68

Tuberculosis—Home Care of Chronic Respiratory Disease 87

Baltimore City Health Department—New Deputy Commissioner 89

Maryland State Department of Health—Growth of Day Care Centers for the Mentally Retarded 95

Heart Page—Effect of Other Drugs on Oral Anticoagulants, Lawrence F. Awalt, MD 103

Maryland State Department of Mental Hygiene—A Report to the Fifteen Southern States 105

Rehabilitation Notes—Rehabilitation of Spinal Cord Injured Patients, Part I: General Introduction, Florence I. Mahoney, MD 113

Library Page—Help! 117

Developing Meaningful Mental Health Statistics, Kurt Gorwitz, ScD 123

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301). ©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland. Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

ON THE COVER: Baltimore's Forward Look as depicted by photographer **Warren Brooks Short, II**

Doctors Take Note **5**

Executive Secretary's Newsletter **9**

Book Reviews **26**

Annual Meeting Notice **29**

MEDIC **33**

Medical News **35**

Scientific Exhibit Reservation Form **38**

Viral Symposium **39**

United Fund is now a Reality **73**

Sports Seminar **75**

Component Society News **81**

Drugs Used in Obstetrics **83**

Woman's Auxiliary **101**

The Month in Washington **107**

Library Accessions **118**

Classified Advertising **134**

Advertising Index **135**

Information for Authors **136**


When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
900541

Doctors take note...

OCTOBER 21, 1969
MARYLAND SOCIETY FOR THE RHEUMATIC DISEASES

Meeting and Discussion—Arthritis and Bowel Disease: Osler Hall, 1211 Cathedral Street, Baltimore, Md. Speaker: Mary Betty Stevens, MD, Associate Professor of Medicine, The Johns Hopkins University School of Medicine.

OCTOBER 22-25, 1969
AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS

District IV Meeting: Shoreham Hotel, Washington, D.C. For further information, contact: The American College of Obstetricians and Gynecologists, 79 W. Monroe St., Chicago, Ill. 60603.

OCTOBER 23, 1969
NEW YORK STATE ACTION FOR CLEAN AIR COMMITTEE

5th Annual Symposium on Air Pollution and Respiratory Disease: New York University Medical Center, 550 First Avenue, Manhattan. A review of the present research on the effects of air pollution on health, and discussions of future alternatives to some of today's air-polluting practices are included in the sessions. Contact: New York State Action for Clean Air Committee, 105 E. 22nd Street, New York, N.Y. 10010.

OCTOBER 23-25, 1969
AMERICAN COLLEGE OF GASTROENTEROLOGY

Annual Course in Postgraduate Gastroenterology: The Rice Hotel, Houston, Texas. For further information and enrollment, contact: American College of Gastroenterology, 299 Broadway, New York, N.Y. 10007.

OCTOBER 24-25, 1969
MEDICAL SOCIETY OF DELAWARE

Annual Meeting: Delaware Academy of Medicine, 1925 Lovering Ave., Wilmington, Del. The House of Delegates will meet on October 24th followed by a Reception of Delegates. The Socio-Scientific Session will be held on October 25th. Registration begins at 8:30 AM on October 25th. Secure a badge from the registration desk for admission to all sessions.

OCTOBER 27-31, 1969
THE LENOX HILL HOSPITAL

Postgraduate Course—Human Endocrinology: Lenox Hill Hospital, New York. The fee is $150.00. For further information, contact: William D. Secher, MD, Coordinator of Medical Education, Lenox Hill Hospital, 100 East 77th Street, New York, New York 10021.

OCTOBER 27-31, 1969
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Office Psychiatry for Internists: Faulkner Hospital, Boston, Mass. Number of registrants: minimum, 15; maximum, 25. This course will deal with the management of the minor psychiatric problems which are encountered by the internist in his office practice. Jack R. Ewald, MD, director; John F. Reichard, MD, and John R. Graham, MD, FACP, co-directors. Contact: Edward C. Rosenow, Jr., MD, Executive Director, American College of Physicians, 4200 Pine St., Philadelphia, Pa. 19104.

OCTOBER 28, 1969
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Acute Renal Failure: University of Maryland Hospital, Baltimore, Md. 21201. Speaker: Glenn Lubash, MD. The conference will be held at the Psychiatric Institute, Room 1-704 at 4:00 PM.

OCTOBER 29-31, 1969
NEW YORK UNIVERSITY SCHOOL OF MEDICINE

3-Day Symposium—"The Pharmacology of Selected Drugs Used in Dermatology: Principles of Action and Uses": Alumni Hall, New York University Medical Center, 550 First Avenue, New York. General principles of drug action, factors influencing drug response and percutaneous absorption will be discussed in depth. Contact: The Office of the Recorder, New York University Postgraduate Medical School, 550 First Avenue, New York, New York 10016.

OCTOBER 29-NOVEMBER 4, 1969
THE NEW YORK FERTILITY RESEARCH FOUNDATION, INC.

Course—Culdoscopy and Infertility: New York Fertility Research Foundation, Inc., New York. Fee is $250.00. For additional information, contact: New York Fertility Research Foundation, Inc., 123 East 89th Street, New York, New York 10028.

NOVEMBER 3-7, 1969
NEW JERSEY COLLEGE OF MEDICINE AND DENTISTRY

Postgraduate Course—A Clinical and Histopathologic Survey of Gynecology: St. Barnabas Medical Center, Old Short Hills Road, Livingston, New Jersey. For further information, contact: James L. Breen, MD, Director, Department of Gynecology and Obstetrics, Martland Hospital Unit, 65 Bergen St., Newark, New Jersey 07107.

NOVEMBER 3-7, 1969
THE AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Nuclear Medicine: Diagnosis and Treatment of Disease with Radionuclides Given Internally: University of Michigan Medical Center, Ann Arbor, Mich. For additional information, contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

NOVEMBER 3-7, 1969
THE AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Mechanisms of Disease and Modern Therapy: The University of Chicago, Chicago, Ill. For additional information, contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

NOVEMBER 5, 1969
COMMITTEE ON POSTGRADUATE EDUCATION, PREVENTIVE MEDICINE AND PUBLIC HEALTH, MEDICAL & CHIRURGICAL FACULTY/NATIONAL COMMUNICABLE DISEASE CENTER

Viral Symposium: 9:30 AM-5 PM, 1211 Cathedral St., Baltimore. *(See page 39 for details.)*

NOVEMBER 5, 1969
AMERICAN CANCER SOCIETY/BALTIMORE CITY AND COUNTY UNITS

Seminar—Head and Neck Cancer: 12 PM, Turner Auditorium, The Johns Hopkins Hospital. Co-chairmen: Arthur Serpick, MD, Charles E. Barr, DDS. Speaker: James Callison, MD, associate professor of plastic surgery, Johns Hopkins Hospital. For lunch reservations and additional information, contact: Don Schroeder, 539-4000, or 825-3091, Baltimore City Unit, American Cancer Society, 824 N. Calvert St., Baltimore, Md. 21202.

NOVEMBER 5-8, 1969
AMERICAN SOCIETY OF CYTOLOGY

Annual Scientific Meeting: Palmer House, Chicago, Ill. The program will include cytology workshops, presentation of scientific papers, luncheons, and a diagnostic cytology seminar. Contact: Warren R. Lang, MD, Secretary-Treasurer, 7112 Lincoln Drive, Philadelphia, Pa. 19119.

(Continued on page 70.)



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.





Maryland's Exclusive Representatives of

OLEG CASSINI
WORLD-FAMOUS FURS

Maryland's oldest and largest furrier

225 N. HOWARD ST.
BALTIMORE, MD. 21201

Mano Swartz

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.



Custom Gifts NOW

We will create a marvelous INDIVIDUAL gift for that Very Special Person. Requires thought, time, craftsmanship—so please do not delay.

Oscar CAPLAN and Sons

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn., Easton, Md. (TA 2-1553)

CAMP TRADE MARK *announces*

a new development in

BRACES



NEW TAYLOR BRACE—designed for comfort, appearance, and effective spinal splinting. Handsome washable slip-on cover helps hold rigid metal back brace firmly in position; also forms part of a body-encircling white jacquard corset. Convenient front closing, with five alternating pull straps for precise adjustment.

DONALD O. FEDDER, ORTHOTIST

Rents and Sells
Hospital Equipment

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

executive secretary's newsletter

October, 1969

LARIFICATION NEEDED

The effects of the Social Security Administration's Intermediary Letter 372, which limits medicare payments to teaching physicians, are being felt nationally by medical educators. According to the letter, a physician must be a patient's "attending physician" in order to receive payment for service. Carriers are required to substantiate claims of attending physicians by checking patient records to determine personal and identifiable services.

In a conversation on August 13, Bureau of Health Insurance Commissioner Thomas M. Tierney, told Ernest B. Howard, MD, Executive Vice-President of the AMA, that this was meant to apply to salaried physicians in a typical medical-school teaching center and not to the practicing physician on a fee-for-service basis in a community hospital with a graduate education program. Mr. Tierney indicated that a clarification of Letter 372 would be considered favorably. It is also reported that the HIBAC Council agrees that this is the intention of the letter.

'RY DUTY FOR PHYSICIANS

Effective July 1, 1969, physicians became liable for Jury duty and were no longer exempted under the laws of Maryland. The same exemption was also stricken from the books for dentists, policemen, attorneys, legislators and others, so that there are no blanket exemptions from this civic responsibility.

It is understood that physicians will be automatically granted exemption. However, under the provisions of the law, applications for exemption may be made on the basis of public need, if not automatically granted.

BORATORY ERVICES

According to State Health Department estimates, residents of Maryland spend approximately $49,000,000 per year for laboratory services. While a good portion of these services are paid for by third-party insurers, much of it is also paid on a personal basis by the patient himself.

HILD BUSE REPORTING

Physicians are reminded that they are required under Maryland law to report suspected cases of child abuse

CHILD ABUSE REPORTING (cont'd)

The local Department of Social Services is the agency charged with investigating such reports. Immunity from prosecution is provided under the law for those making reports in good faith. The intent of the law is to protect the child or siblings from further abuse. The fact that an abuser has been arrested and pending trial does not mean that the child is protected.

LETTERS IN MAIL ON PROFESSIONAL INCORPORATIONS

In the mail to all faculty members is a communication from the Med-Chi Insurance Trust. It offers an opportunity for personal consultation together with an attorney, tax counselor or others, on the advantages and disadvantages of professional incorporation as applied to an individual's practice.

You may return the card or call the Faculty office for an appointment.

STRANGE WORKINGS

The U.S. Government's Department of Agriculture spen $68.5 million last year to support the price of tobacco HEW and the same Agriculture Department together spent $6.3 million to discourage its use.

FAMILY PRACTICE CERTIFICATION

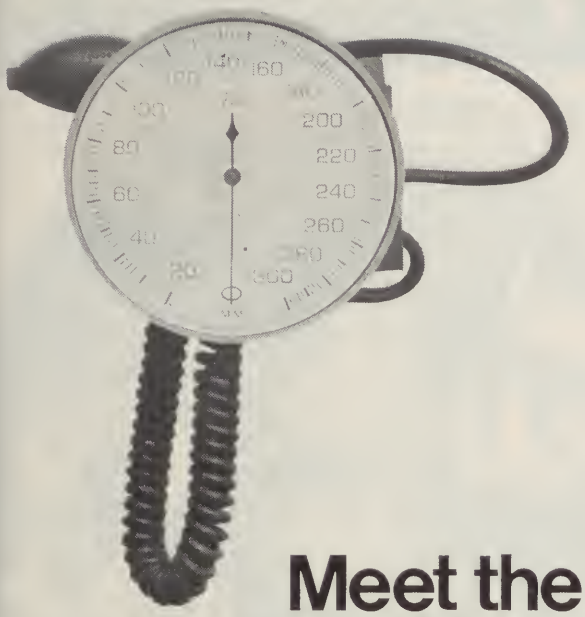
The American Board of Family Practice will give its first certification examination on February 28 through March 1, 1970. Information regarding the examinatio eligibility and where it will be given may be obtained from:

Nicholas J. Pisacano, M.D., Secretary
American Board of Family Practice, Inc.
University of Kentucky Medical Center
Annex #2, Room 229
Lexington, Kentucky 40506

THE FALL GUY

Despite pressures and undue publicity directed against physicians for high costs of Medicaid and Medicare, only 11% of total costs of these programs go for physician's services.

John Sargeant
Executive Secretary



Meet the new Tycos wall mounted Aneroid. You can read it from anywhere in the room.

- Big 6¼" dial. Large black numerals on white background. Easy to read from anywhere in the room.
- Positive swivel action for setting in several positions on stainless steel bracket.
- Non-glare neutral case. No chrome. Shatterproof crystal. Simple in design and easy to clean.
- Visual check for accuracy — exclusive with all Tycos aneroids.
- Choice of hook or velcro cuffs. 6-foot coiled cord standard.

Murray Baumgartner
Surgical Instrument Co., Inc.
2501 Gwynns Falls Parkway at Warwick Ave.
Phone: 669-9300 Baltimore, Md. 21216

BUSINESSWISE

DOCTOR

PROBLEMS WILL ARISE

IN

INDIVIDUAL PRACTICE
PARTNERSHIP
CORPORATION

OR

DIRECT BILLINGS
AND
COMPUTER STATEMENTS

◆

OUR EXPERIENCED SUPERVISION
AND "KNOW HOW"
ARE AT YOUR ELBOW

◆

DIAL 752-5920

Professional Management Co.

708 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN

The AMBAR® SCRAPBOOK of Obesity Oddities
FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

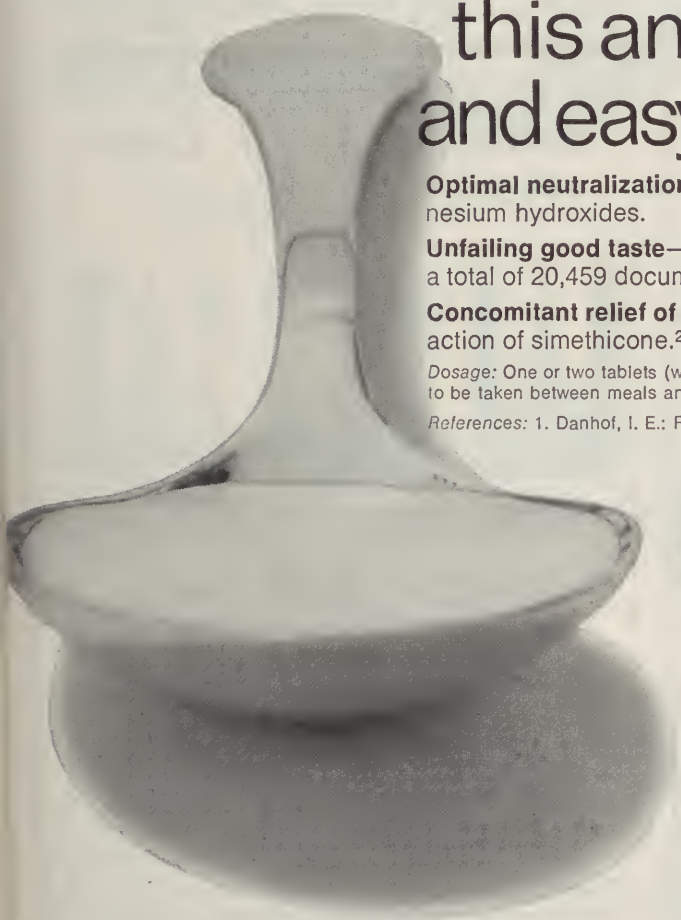
Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ INGLESIDE SHOPPING CENTER
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ HILLENDALE SHOPPING CENTER
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

attention doctors--

When you guard the health of your funds by investing them where they are safe and accessible, you're practicing preventive medicine against inflation. And, funds grow at a gratifying rate through DAILY compounding of dividends.

5.23%
ON PASSBOOK ACCOUNTS
Effective Annual Yield
Compounded & Computed DAILY

Guaranteed Protection
Accounts insured up to $20,000 by the Maryland Savings Share Insurance Corp.

SECURITY
Savings & Loan
(a stock corporation) Organized 1895

24 E. Fayette at St. Paul Street Phone: 727-4415

DOCTOR

Do you need an Audiometer? Whatever your needs in hearing test equipment . . . you can rely on MAICO.

Do you need auditory training systems for training the deaf and hard of hearing?

MAICO HAS IT!

Does your patient need a hearing aid? For professional, dependable hearing help, you can rely on your MAICO Dealer.

Most Respected Name in Hearing

MAICO HEARING AIDS, Inc.

Paul O. Standon

318 W. Saratoga St. Baltimore, Md. 21201

Phone 752-4545

Growing Feet Can Have Problems!



PRONATION KNOCK-KNEES PIGEON-TOES

These common problems can be helped with proper shoes, correctly fitted.

Prescriptions Carefully Filled

VAN DYKE & BACON

307 N. Charles St. SAratoga 7-3775
5849 York Rd. IDlewood 3-1100
Baltimore, Maryland



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

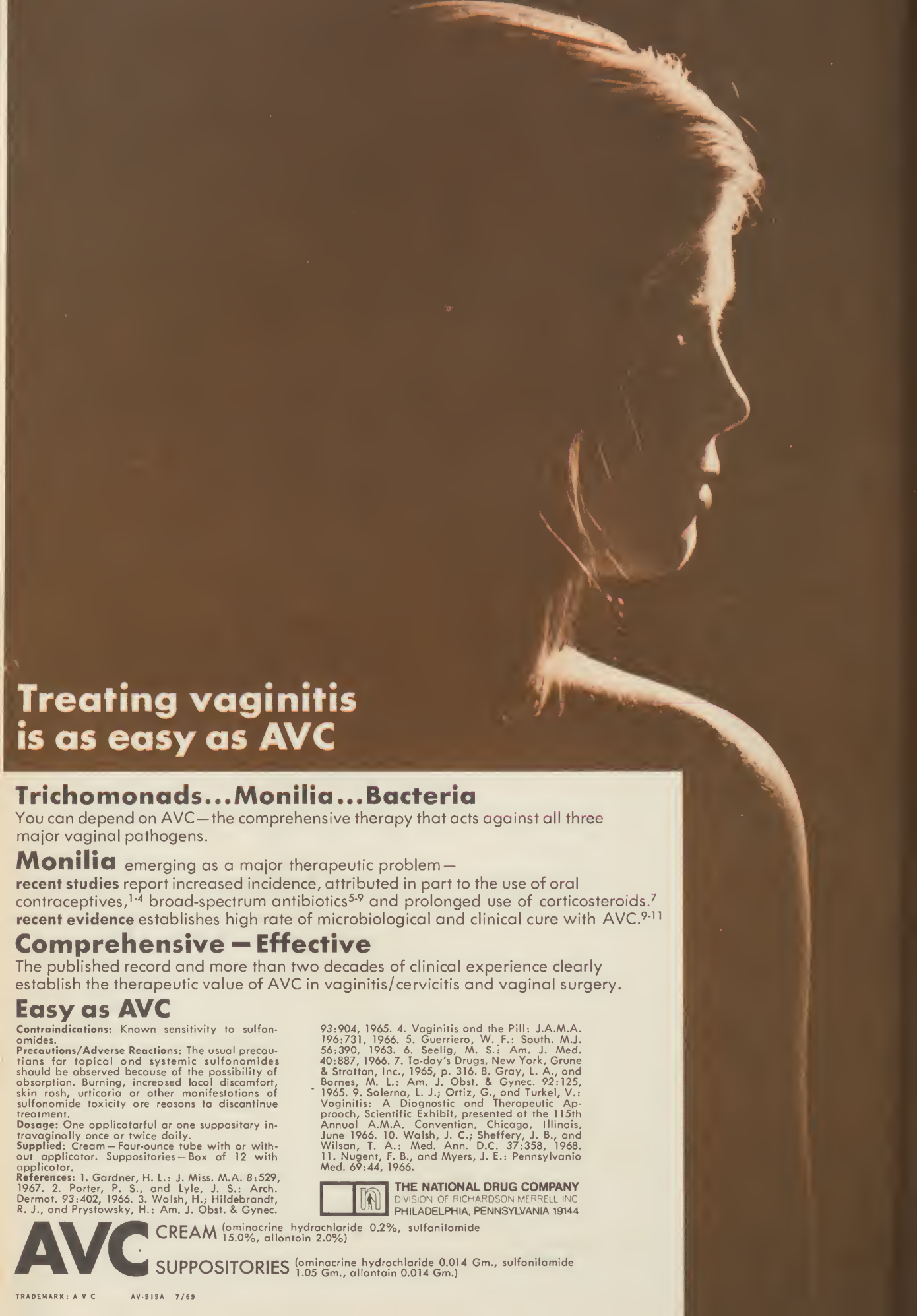
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonomides.
Precautions/Adverse Reactions: The usual precautians far topical ond systemic sulfonomides shauld be observed because af the possibility af obsorption. Burning, increased locol discamfort, skin rosh, urticoria or other monifestotions of sulfonomide toxicity ore reosons to discantinue treotment.
Dosage: One applicotarful or one suppasitary intravaginolly once or twice doily.
Supplied: Cream—Faur-ounce tube with or without applicator. Suppositories—Box af 12 with applicotor.

References: 1. Gardner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., and Lyle, J. S.: Arch. Dermot. 93:402, 1966. 3. Walsh, H.; Hildebrandt, R. J., ond Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Vaginitis ond the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. Ta-doy's Drugs, New York, Grune & Strattan, Inc., 1965, p. 316. 8. Gray, L. A., ond Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerna, L. J.; Ortiz, G., ond Turkel, V.: Voginitis: A Diognostic ond Therapeutic Approoch, Scientific Exhibit, presented at the 115th Annual A.M.A. Conventian, Chicago, Illinais, June 1966. 10. Walsh, J. C.; Sheffery, J. B., and Wilsan, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., and Myers, J. E.: Pennsylvanio Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

AVC CREAM (ominocrine hydrachlaride 0.2%, sulfanilomide 15.0%, allontoin 2.0%)

SUPPOSITORIES (ominacrine hydrochlaride 0.014 Gm., sulfonilamide 1.05 Gm., allantain 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And free your secretary to be your secretary again.

professional systems and services *division of*

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3886



THE BREAKUP of a business partnership, the crack-up of a marriage, the shake-up of being fired or reduced to bankruptcy... after any significant loss or severe blow to self-esteem, *both* anxiety and depression almost always follow.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.



FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

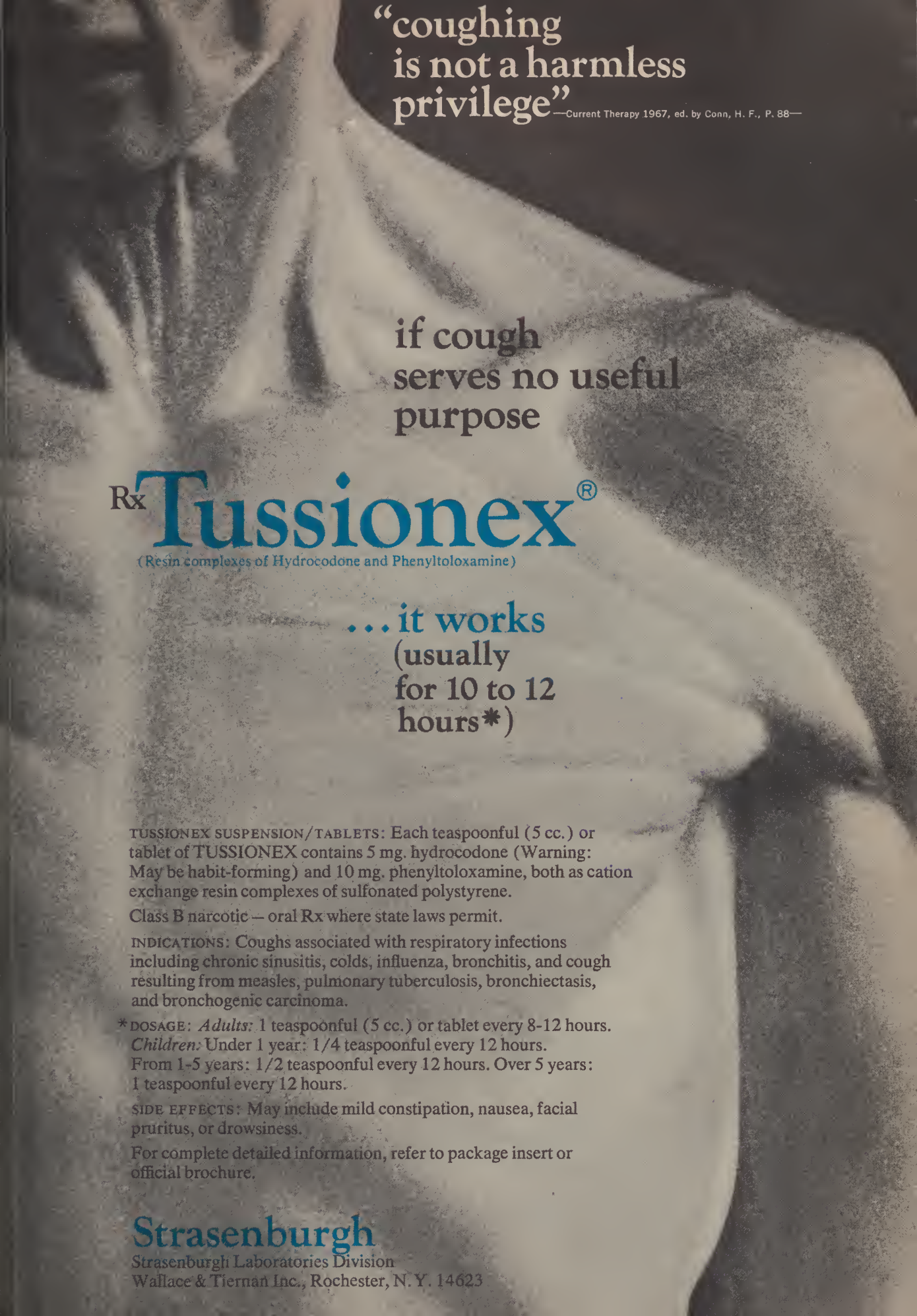
SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasias (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, up to exfoliative dermatitis); other allergic reactions (asthma, laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions; cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes; catatonic-like states; autonomic reactions such as dryness of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information consult your Merck Sharp and Dohme representative or see the package circular.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co., Inc., West Point, Pa. 1948
where today's theory is tomorrow's therap



TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

Class B narcotic — oral Rx where state laws permit.

INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.

*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.

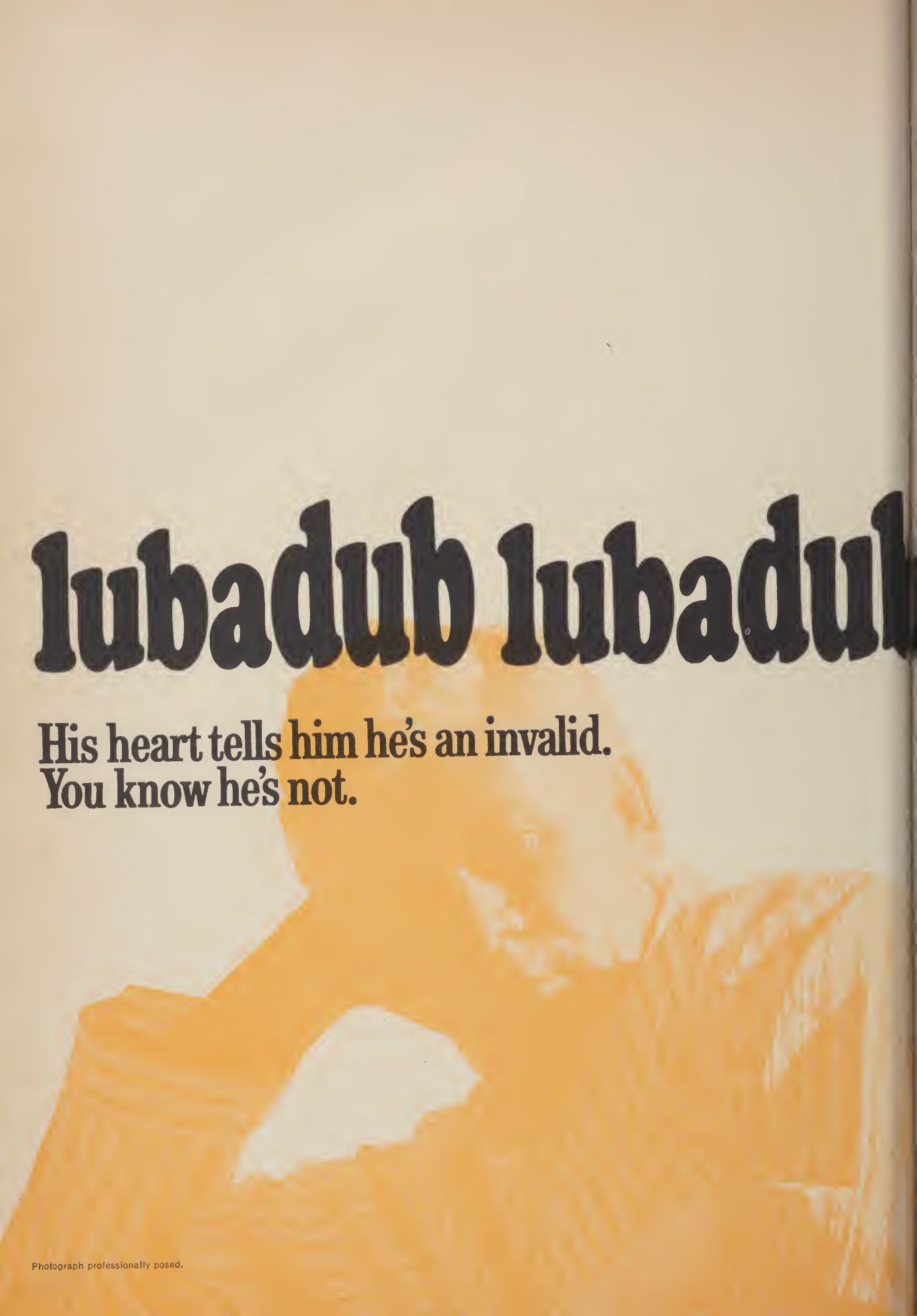
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.

For complete detailed information, refer to package insert or official brochure.

Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

badubdub lubadu

Anxiety is expected in the cardiovascular patient. A little may even be desirable.

But when anxiety is exaggerated . . . when it interferes with sleep . . . when it aggravates cardiovascular symptoms, your help may be needed.

Naturally, you'll want to reassure the patient.

And perhaps prescribe Equanil (meprobamate) as adjunctive therapy. It helps relieve anxiety and tension specifically, yet gently.

Almost 15 years' use has shown that Equanil is usually well tolerated as well as effective. Side effects are generally limited to transient drowsiness; serious, therapy-interrupting side effects are rare.

stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®



No place for beginners

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



Terramycin®
(oxytetracycline)

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017

...because we believe you're entitled to the

MAXIMUM DIVIDENDS

☆ 1-Year Certificates

Our Series "A" Certificates offer the *highest* allowable Dividend Rate of 5.25% . . . plus the assurance of safety! Issued in amounts of $12,000 or larger, with increments of $1,000. (Also available, Series "B" Certificates of $5,000 or more, yielding 5.00%)

☆ Passbook Accounts

Providing the *highest* allowable Passbook Dividend Rate of 4.75%, with insured safety! Open and add to your account with any sum . . . you Gain Every Month and *keep what you gain*, because dividends are figured Monthly, and paid Quarterly! Open your account now!

A GEM OF A PLAN TO SAVE YOURSELF

American National

BUILDING & LOAN ASSN.

LEXINGTON AND LIBERTY STS., BALTIMORE
TOWSON PLAZA • PERRY HALL • FALLSTAFF
HARUNDALE MALL • WESTVIEW

Passbook Funds Received by 10th, Earn Dividends for the Entire Month

INSURED

FEDERAL HOME LOAN BANK SYSTEM MEMBER

Accounts Insured up to $15,000 by an Agency of the U.S. Government

Pay 'Phone or Gas & Electric Bills at Any Office.
Money Orders and Travelers' Checks Available

Book Reviews

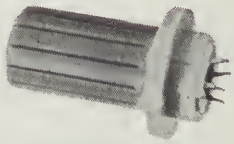
YOUR COMMUNITY HOSPITAL, Robert E. Walsh; Beacon Press, Boston, 1969.

This book concerns the quality of hospital care a patient is likely to receive. It is directed toward the American citizen in his community in order to explain the functions and services a hospital is supposed to perform. In his attempt to make the public more aware, the author poses the question: What can a private citizen do to help the hospital improve its health care programs?

> ". . . If health care of a high quality is a right, there certainly must be a corollary which puts a responsibility on the citizen to know and understand what is available and how to use it most effectively. It would appear to be true that the voluntary health organizations, the political and civic groups, and the labor movement, which have insisted

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.

that health care is a basic right, now have some responsibility to see that this right is not abused and also to see that communities use these health services in the most efficient manner."

Another interesting point which Mr. Walsh makes involves rising hospital costs. He suggests that labor stop criticizing hospitals for the rising cost of patient care, since labor itself is one of the reasons for this escalation.

In conclusion, the book is informative and well worth your reading. However, it is doubtful those persons who would benefit the most from reading the book will exert themselves enough to pick it up.

TEXTBOOK OF PEDIATRICS, Waldo E. Nelson, MD; The W. B. Saunders Company, Philadelphia, 1969.

The great increase in medical knowledge and the potentials for application of it to the medical care of children have necessitated the sharing of the responsibility of publication of this book with other medical writers. This book continues to provide, in a single volume, the synthesis of pediatric knowledge which will be appropriate for the student as an introduction to pediatrics and for the clinician as a useful and competent reference.

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

Geo. RADEBAUGH
& Sons

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of the weight-control program *you* recommend. It reduces the appetite. Doesn't kill it. Weight loss is significant—gradual—yet there is a relatively low incidence of CNS stimulation. Because TEPANIL works on the appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in potients hypersensitive to this drug; in emotionally unstoble patients susceptible to drug obuse.

Warning: Although generally sofer thon the omphetomines, use with greot coution in patients with severe hypertension or severe cardiovoscular diseose. Do not use during first trimester of pregnoncy unless potential benefits outweigh potentiol risks.

Adverse Reactions: Rarely severe enough to require discontinuotion of therapy, unpleasant symptoms with diethylpropion hydrochloride have been reported to occur in relatively low incidence.

As is choracteristic of sympothomimetic ogents, it may occasionally couse *CNS effects* such as insomnio, nervousness, dizziness, onxiety, and jitteriness. In controst, CNS depression hos been reported. In o few epileptics an increose in convulsive episodes hos been reported.

Sympothomimetic *cordiovosculor effects* reported include ones such os tochycordia, precordial poin, orrhythmio, polpitotion, and increosed blood pressure. One published report described T-wove changes in the ECG of o healthy young male after ingestion of diethylpropion hydrochloride; this wos on isoloted experience, which has not been reported by others.

Allergic phenomeno reported include such conditions os rosh, urticorio, ecchymosis, ond erythema. *Gostrointestinol effects* such os diorrheo, constipotion, nouseo, vomiting, ond obdominal discomfort have been reported.

Specific reports on the hemotopoietic system include two each of bone morrow depression, ogronulocytosis, and leukopenio.

A voriety of miscellaneous adverse reoctions have been reported by physicions. These include complaints such os dry mouth, heodoche, dyspnea, menstruol upset, hoir loss, muscle pain, decreosed libido, dysuria, ond polyuria.

Convenience of two dosage forms: TEPANIL Ten-tab tablets: One 75 mg. tablet daily, swallowed whole, in midmorning (10 o.m.); TEPANIL: One 25 mg. tablet three times daily, one hour before meals. If desired, an additionol toblet moy be given in midevening to overcome night hunger. Use in children under 12 years of oge is not recommended.

Tepanil® Ten-tab®

(cantinuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/69

172nd ANNUAL MEETING

Medical and Chirurgical Faculty of the State of Maryland

APRIL 1, 2, 3, 1970

Scheduled for the 1970 Annual Meeting are many prominent speakers, such as

John Rock, MD, Boston

George James, MD, Dean of Mount Sinai School of Medicine, New York

Dan M. Gordon, MD, New York

Felix Wroblewski, MD, Brookdale Hospital Center, New York

Roy W. Menninger, MD, President of The Menninger Foundation, Topeka, Kansas.

Medical and Surgical Grand Rounds will be presented by the Department of Medicine of The Johns Hopkins and the Department of Surgery of the University of Maryland.

Other activities scheduled are

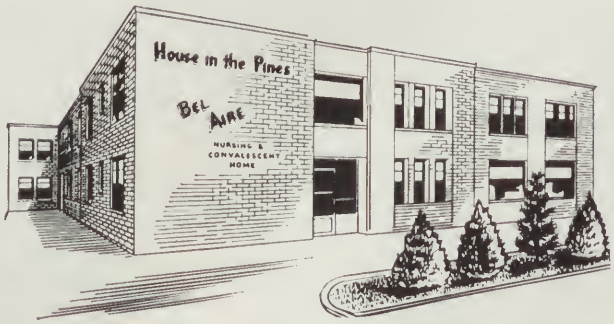
Annual Round-Table Luncheon, which will include luncheon meetings of the alumni associations of several medical schools

Hospitality Night—this proved so very popular at the 1969 Meeting, that it will be repeated in 1970

Annual Presidential Reception and Banquet—at the Blue Crest North, well known for its delectable cuisine, hors d'oeuvres, and cocktails—in a delightful atmosphere

When Professional Experience Counts

The House In The Pines Staff Is Able and Ready To Serve!



BEL AIRE . . . 5837 Belair Road • CL 4-8800

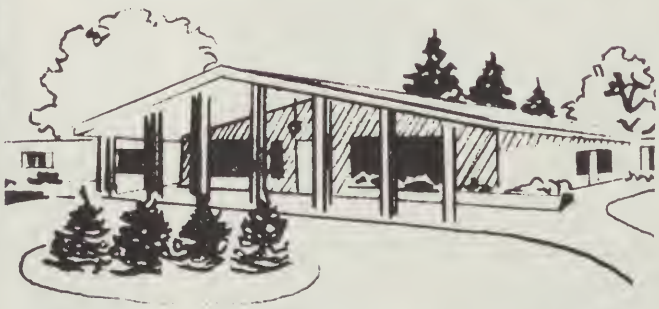


BELVEDERE . . . 2525 W. Belvedere Ave. • FO 7-9100

Conveniently located 1 block from Sinai Hospital.



CATONSVILLE . . . 16 Fusting Avenue • RI 7-1800



EASTON, Md. . . . Rt. 50 & Dutchman's Lane • TA 2-4000

HOUSE IN THE PINES Nursing and Convalescent Homes offer efficient, round the clock care under the direct supervision of registered nurses, 24 hours a day.

The aged, convalescent and the chronically ill guests enjoy a modern, home-like atmosphere with the most up-to-date medical and therapy equipment at their side.

Complete physical and occupational therapy programs are available. The recreational programs are designed to full-fill the needs and desires of our guests.

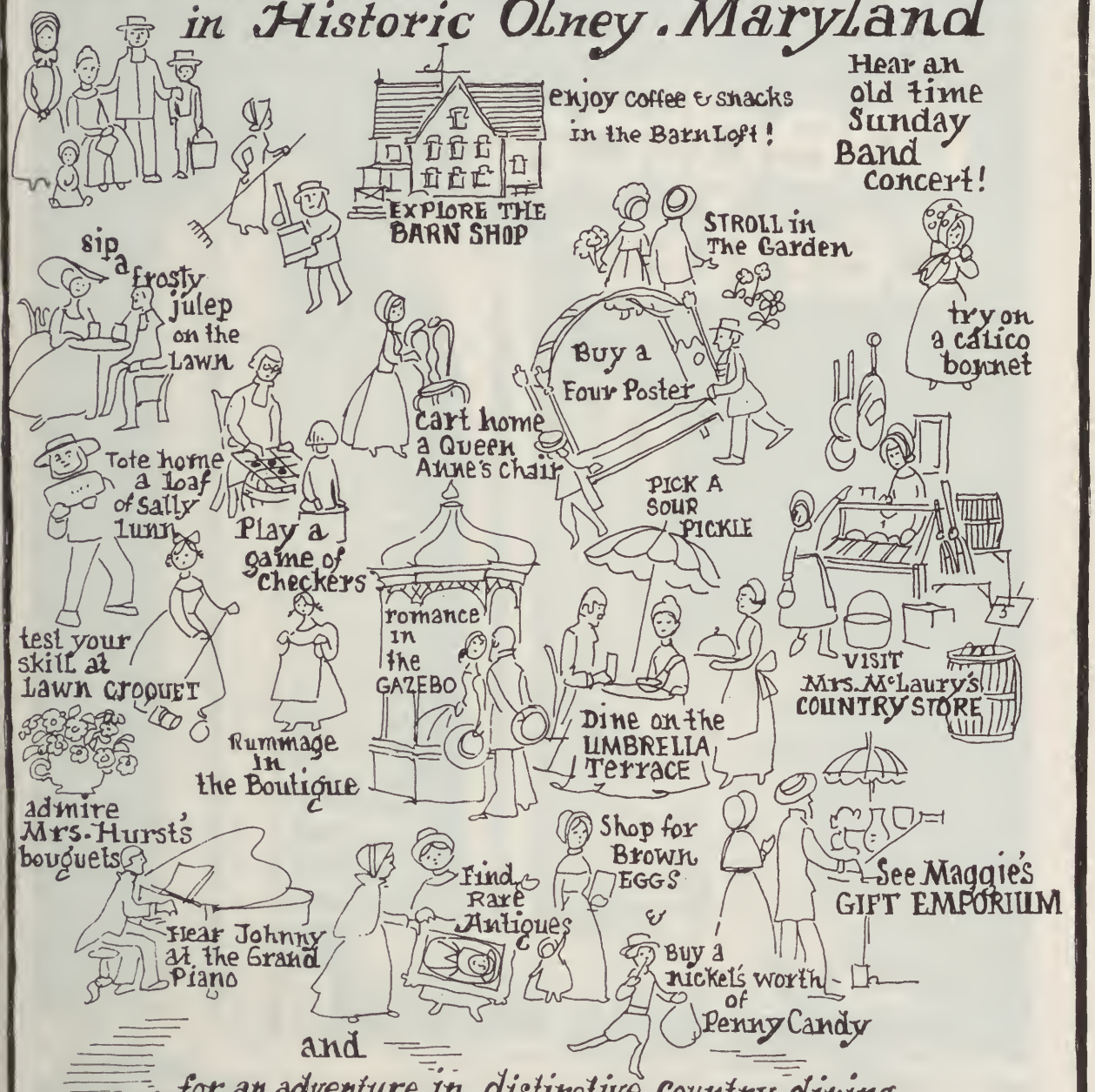
Excellent food is served, and special diets catered to, under the direct supervision of our licensed staff dietician.

Physicians orders are followed explicity!

HOUSE IN THE PINES
NURSING HOMES

Your Inspection Invited
Brochure Upon Request

MEET THE FRIENDLY FOLK
in Historic Olney . Maryland



and

for an adventure in distinctive Country dining

it's **Olney Inn**

BARN SHOP & COUNTRY STORE

FROM D.C. 16TH ST. TO GA. AVE - NORTH. RT 97 TO OLNEY
FROM BALTIMORE - RT. 40 TO 29. 29 TO 108 THROUGH ASHTON TO OLNEY

PHONE 929-1717

in the heart of the Friendly Country

Open 7 Day a week!



The doctor who doesn't have the proper prescription for planning his estate is inviting a bad case of unnecessary taxes. How about you? If you're vulnerable, we and your attorney have the cure. Call our Dick Flanigan at 539-1040 and arrange an appointment. You needn't wait for our new building to be completed either. We make house calls.

MERCANTILE-SAFE DEPOSIT and TRUST COMPANY

MEDIC 1969–1970 SCHEDULE

OF POSTGRADUATE PROGRAMS

presented through

Medical Education's Dedicated Instructional Channel

Supported in part by a grant from Merck Sharp and Dohme

OCTOBER 24, 1969 — 12:30 PM

INFECTIOUS MONONUCLEOSIS

Dexter Seto, MD
Assistant Professor of Pediatrics
The Johns Hopkins University School of Medicine

This discussion will cover several clinical aspects of infectious mononucleosis, the various manifestations and complications, and laboratory aids in diagnosis. Current concepts in etiology will also be considered.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:	Monday, October 27, 1969	12:30 PM
	Wednesday, October 29, 1969	9:00 AM
		2:00 PM

OCTOBER 31, 1969 — 12:30 PM

ALCOHOLISM

Roland Smoot, MD
Chief of Medicine
Provident Hospital

Maxwell N. Weisman, MD
Director, Division of Alcoholism Control
State Department of Mental Hygiene

The speakers will discuss the specific role of the general hospital in coping with the acute phase of alcoholism, but will also consider the responsibility of other community agencies which may serve as allies to the physician in managing the chronic illness within the framework of a comprehensive public health program.

Sponsor: PROVIDENT HOSPITAL

Replays:	Monday, November 3, 1969	12:30 PM
	Wednesday, November 5, 1969	9:00 AM
		2:00 PM

NOVEMBER 7, 1969 — 12:30 PM

OVARIAN DYSFUNCTION

Georgeanna Seegar Jones, MD
Associate Professor of Obstetrics and Gynecology
The Johns Hopkins University School of Medicine

Ovarian dysfunction can be clinically characterized by irregular or absent periods or prolonged or profuse menses. The decision as to whether or not the symptoms require investigation or treatment must be made on the basis of the individual case. When primary amenorrhea exists, it is always important to determine if an associated abnormality of the genitalia exists. No intelligent approach can be made to therapy of ovarian dysfunction until a proper etiologic diagnosis has been obtained. With the addition of human pituitary gonadotrophin and clomiphene citrate to our therapeutic armamentarium, the results of therapy are more encouraging.

Sponsor: SACRED HEART HOSPITAL

Replays:	Monday, November 10, 1969	12:30 PM
	Wednesday, November 12, 1969	9:00 AM
		2:00 PM

NOVEMBER 14, 1969 — 12:30 PM

PROBLEMS OF POLYARTHRITIS

Mary Betty Stevens, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Patients with acute polyarthritis, of recent onset, present difficult problems in diagnosis and management. The approach to differential diagnosis, clinical and laboratory study, will be discussed. Therapeutic regimens and philosophy of management will be outlined. Individual cases of illustrative value will be presented.

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:	Monday, November 17, 1969	12:30 PM
	Wednesday, November 19, 1969	9:00 AM
		2:00 PM

NOVEMBER 21, 1969 — 12:30 PM

PRE-ECLAMPSIA AND ECLAMPSIA

Frank Kaltreider, MD
Chief, Department Obstetrics and Gynecology
Baltimore City Hospitals

Rafael Garcia, MD
Assistant Chief of Pathology
Baltimore City Hospitals

Pre-eclampsia is a preventable disease. Pre-eclampsia is commonly associated with varied complications. For these reasons warning signs, apparently innocent, cannot be ignored.

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, November 24, 1969	12:30 PM
	Wednesday, November 26, 1969	9:00 AM
		2:00 PM

(Continued next page)

NOVEMBER 28, 1969 — 12:30 PM

CURRENT IMMUNIZATION PRACTICES

David H. Carver, MD
Associate Professor of Pediatrics
Associate Professor of Microbiology
The Johns Hopkins University School of Medicine

This discussion will deal with a suggested schedule of immunization of children and will emphasize particularly the new vaccines, mainly measles, mumps, and rubella.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:	Monday, December 1, 1969	12:30 PM
	Wednesday, December 3, 1969	9:00 AM
		2:00 PM

DECEMBER 5, 1969 — 12:30 PM

OBESITY

Simeon Margolis, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine
University of Maryland School of Medicine

An increasing number of patients are turning to physicians for assistance in weight reduction and for treatment of the complications of obesity. Management of the obese patient is an extremely frustrating medical problem, but may involve dietary, drug, and psychiatric measures. This talk will cover the pathogenesis, complications, and management of obesity.

Sponsor: SACRED HEART HOSPITAL

Replays:	Monday, December 8, 1969	12:30 PM
	Wednesday, December 10, 1969	9:00 AM
		2:00 PM

CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

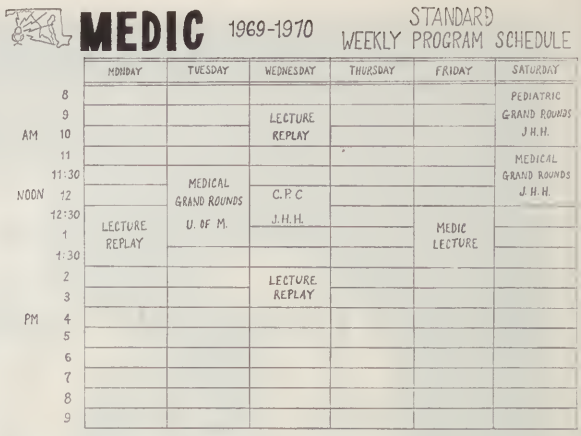
SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

November 25	January 27
February 24	March 24
April 28	May 26



OTHER SPONSORS:

Medical and Chirurgical Faculty of the State of Maryland

State Department of Health

Hospital Council of Maryland

Participating hospitals:
Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Physicians Memorial, LaPlata
Prince George's General, Cheverly
Provident, Baltimore
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Veterans Administration, Loch Raven, Baltimore
Washington County, Hagerstown

Other locations:
Baltimore County Health Dept., Towson
Civil Defense Headquarters, Baltimore
Hospital Council of Maryland, Inc., Baltimore
Medical and Chirurgical Faculty, Baltimore
State Department of Health, Baltimore

For further information contact:
Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
(301) 539-0872

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201, (301) 383-3010 Ext. 8722

MEDICAL NEWS

On August 31, 1969, **Jacob H. Conn, MD,** Assistant Professor of Psychiatry at The Johns Hopkins University School of Medicine, discussed his method of Hypnosynthesis at the organizational meeting of the first Hypnosis Section to be established by the American Psychological Association at its annual meeting in Washington, D. C.

Dr. Conn was the first practicing psychiatrist to be certified in Maryland by the American Board of Psychiatry and Neurology in 1935 and first to be certified in Child Psychiatry in 1959. In 1968, he received the award for the best paper on clinical hypnosis. Dr. Conn is past president of the American Board of Medical Hypnosis and of the National Society for Clinical and Experimental Hypnosis.

* * *

The American Association of Blood Banks in Chicago and **The American National Red Cross** in Washington, D. C. announced recently that Americans in good health can now be blood donors until their 66th birthday instead of the 60th or 61st as in the past. According to Frank Coleman, MD, of Tampa, Florida, the standards for blood donation were liberalized because Americans are living longer due to better medical care and better nutrition, and the need for blood is constantly increasing at a rate of about 12% annually.

* * *

David Rogers, MD, Dean of The Johns Hopkins School of Medicine, will be guest speaker before **the Professional Forum** at this group's monthly dinner-seminar at the Baltimore Country Club on Tuesday evening, November 18th. Dean Rogers will speak on "The Problems of Patient Care Today." A question and answer session will follow the discussion.

Established in early 1965, the Professional Forum consists of local physicians, dentists, certified public accountants, educators, clergymen, judges, lawyers, criminologists and behavioral scientists, each group represented by its own committee.

In addition to maintaining a close liaison with county, state, and national professional associations, the Professional Forum provides educational programs, workshops, and guest speakers to business, civic, professional, and college audiences.

* * *

The U. S. Agency for International Development has requested that the AMA continue its administration of the program for an additional two years. Four hundred additional volunteers are needed to maintain 32 physicians in Viet Nam until June 1971. The greatest need is for general practitioners, general surgeons, internists, orthopedic surgeons, pediatricians, and preventive medicine specialists.

Interested physicians should contact the Director, Volunteer Physicians for Viet Nam Program, American Medical Association, 535 North Dearborn, Chicago, Illinois 60610.

* * *

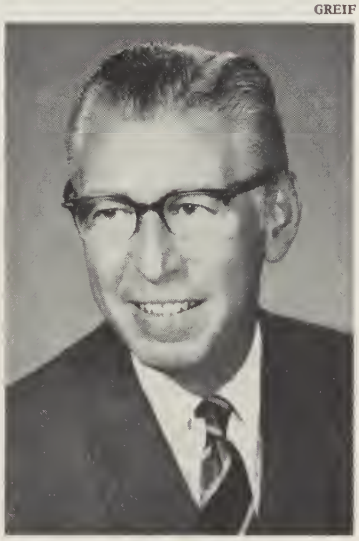
J. H. Mason Knox, 3d, MD, has been elected chief of the medical staff and chairman of the medical board of Church Home and Hospital. He succeeds James C. Owings, MD. Dr. Knox was graduated from The Johns Hopkins Medical School in 1938, after receiving his undergraduate degree from Yale.

A general surgeon, Dr. Knox interned at Union Memorial and completed his residency at the Church Home and Hospital. During World War II, Dr. Knox served with the 4th Auxiliary Surgical Group of the 3rd Army. As a captain, he headed a surgical team, and earned the Bronze Star.

* * *

Edward F. Lewison, MD, Chief of the Breast Clinic of The Johns Hopkins Hospital, has been appointed Vice-Chairman of the World Health Organization's International Committee on Breast Cancer. Dr. Lewison and The Johns Hopkins Hospital will represent the United States at the next meeting in Geneva, Switzerland, in December.

GREIF



Dr. Lewison

* * *

The California Medical Association recently published a new edition of the *Relative Value Studies* in September, which will

become effective for usage in California on April 1, 1970. This book contains a complete listing of procedures performed by physicians and unit values which indicate the relationship of values of services to each other. It is designed to assist physicians, health insurance carriers, consumers, and business to identify procedures which physicians perform.

Copies of the revised edition of *Relative Value Studies* may be obtained by writing to: Six-Ninety-Three Sutter Publications, Inc., 693 Sutter Street, San Francisco, Calif. 94102.

* * *

The National Institute of Mental Health's Center for Studies of Crime and Delinquency sponsored a two-day conference in Chevy Chase, Maryland, on June 19 and 20, 1969. Members of the conference, including experts in the fields of genetics, psychiatry, psychology, sociology, and law discussed a possible link between the XYY syndrome and criminal behavior.

Chaired by **Park Gerald, MD,** of Boston's Children's Hospital, members of the conference concluded that although the general impression has been conveyed that the presence of the XYY chromosome is clearly related to criminal behavior, there is no definite evidence of a connection between the two at the present time.

Guidelines were also developed at the conference for further research and study of the subject.

* * *

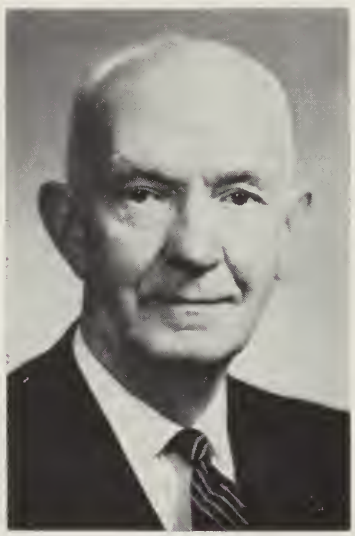
Horace L. Hodes, MD, chairman of the department of pediatrics at Mount Sinai Hospital in New York, has been named as the first Herbert H. Lehman Professor of Pediatrics at the hospital's new school of medicine. The pediatrics chair has been endowed by Mrs. Herbert H. Lehman in memory of her husband.

Dr. Hodes has been the director of pediatrics at the Mount Sinai Hospital since 1949, and will continue in that position while he also heads the school's department.

He is recognized as one of the country's leading authorities on viral and infectious diseases, and for his contributions to the development of techniques for treating children's diseases. Among the notable achievements of Dr. Hodes and his colleagues have been the discovery of the major role of action of vitamin D and the development of a rabies vaccine which was the first completely noninfectious, but immunologically active antiviral vaccine.

After graduating from the University of Pennsylvania College of Medicine and before coming to the Mount Sinai Hospital, Dr. Hodes was associated with The Johns Hopkins Hospital and Medical School in Baltimore, and was director of Sydenham Hospital, Baltimore.

* * *



Dr. Walsh

Frank Burton Walsh, MD, Professor Emeritus in Ophthalmology, Wilmer Institute, Johns Hopkins Hospital, was chosen by the Pennsylvania Academy of Ophthalmology and Otolaryngology to be guest of honor at its annual convention held in Bedford, Pennsylvania, on May 24, 1969. Dr. Walsh was presented with a plaque commemorating the occasion in appreciation of his contribution to the medical profession in the field of neuro-ophthalmology. He has taught at the Wilmer Institute as professor of ophthalmology since 1958 and has been professor emeritus since 1962.

Dr. Walsh attended Queen's University in Canada and received his MD from the University of Manitoba. He has received honorary doctor of science degrees from the University of Western Australia and from the University of Manitoba. Queen's University has awarded him an LLD, an honorary doctor of laws degree.

* * *

Malcolm L. Peterson, MD, PhD, of the Washington University School of Medicine in St. Louis, has been named director of the new Health Services Research and Development Center at The Johns Hopkins Medical Institutions, effective July 1.

The appointment was announced in May, 1969, by Russell A. Nelson, MD, president of The Johns Hopkins Hospital; David E. Rogers, MD, dean of the School of Medicine; and John C. Hume, MD, dean of the School of Hygiene and Public Health.

Dr. Peterson has also been appointed associate professor both in the department of medicine of the School of Medicine, and in the School of Hygiene and Public Health.

Dr. Peterson received his bachelor's degree from Stanford University in 1950, and his medical degree with honors from the University of Washington, Seattle, in 1954. He also holds a PhD in biochemistry, awarded by the Rockefeller Institute in 1960.

* * *

Dwight L. Wilbur, MD, immediate Past-President of the AMA, has stressed the vital importance of increasing the efficiency and economy of the rapidly growing Medicaid program. According to Dr. Wilbur, "In 1968 it cost $3,500,000,000 and served 8,500,000 people. It is likely that in fiscal 1970 it will cost $4,862,000,000 and serve 10,200,000 people. And estimates of costs, if the present law is in effect in 1975, range from $12 to $16 billion."

Dr. Wilbur and his associates are hoping for an improved Medicaid program that will be more efficient and better managed. Significant cooperation is also being received from the states, hospitals, allied professions, and physicians. Presently, medical care to the poor, on a welfare basis, is being abandoned for new programs that will enable needy people to receive the same quality of medical care from hospitals and private physicians as do more affluent citizens.

* * *

Leo Kanner, MD, FAAP, Professor Emeritus of Child Psychiatry, The Johns Hopkins University School of Medicine, has been named by the American Academy of Pediatrics to receive its 1969 C. Anderson Aldrich Award for outstanding contributions in the field of child development.

Significant aspects of Dr. Kanner's career include the identification of a disorder he termed "early infantile autism" which has become widely known as Kanner's Syndrome. His analysis of this disorder and its psychological and pathological features have greatly contributed to the study of psychosis in early childhood. Dr. Kanner's outstanding contributions to child psychiatry as a Commonwealth Fund Fellow, from 1928-1930 at Johns Hopkins, led to his selection as the first director of the first division of psychiatry within a department of pediatrics. Hopkins established the division in 1930, and Dr. Kanner served as director for 29 years.

Dr. Kanner received his MD degree from the University of Berlin in 1921.

* * *

NMA LEADERS MEET WITH PRESIDENT NIXON



President Nixon expresses his gratitude to Emerson C. Walden, MD, of Baltimore and Columbia, Chairman of the Board of Trustees of the National Medical Association, and other leaders of the organization who took time out from their 74th Annual Convention in San Francisco to confer with him at the West Coast White House. With the President and Dr. Walden are (from left): James M. Whittico, Jr., MD, of St. Louis, out-going President of NMA; Julius W. Hill, MD, Los Angeles, incoming President, and John L. Wilks, Deputy Assistant Secretary of Labor for Compliance and Director of the Labor Department's Office of Federal Contract Compliance.

Emerson C. Walden, MD, of Baltimore, Chairman of the National Medical Association Board of Trustees, was among the Negro delegation who met with President Nixon in August to discuss the present welfare system. Accompanying Dr. Walden were **James M. Whittico, MD,** of St. Louis, outgoing president, and **Julius Hill, MD,** of Los Angeles, incoming president of NMA.

The NMA leaders, attending the 74th Annual Convention and Scientific Assembly in San Francisco, told the President they were pleased with his proposal to overhaul the present system, and were impressed with his awareness of the shortage of Negro physicians. Dr. Hall described the meeting as "quite fruitful."

* * *

SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

APRIL 1, 2, 3, 1970

The Alcazar, Baltimore

As space is limited, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

7. Name of institution cooperating in the exhibit: _____

_____

8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS

WEDNESDAY, NOVEMBER 5, 1969

SYMPOSIUM ON VIRAL DISEASES

Osler Hall, 1211 Cathedral Street, Baltimore

Cosponsored by the Medical and Chirurgical Faculty of Maryland and the National Communicable Disease Center

9:30 AM Welcome and Introductions ..... **John Whitridge, Jr., MD**
Chairman, Committee on Postgraduate Education, Preventive Medicine, and Public Health, Medical and Chirurgical Faculty.

9:35 AM Introductory Remarks ..... **Richard B. Hornick, MD**
Moderator
Associate Professor of Medicine and Director, Division of Infectious Diseases, University of Maryland School of Medicine

9:40 AM Advances and Horizons in Virology ..... **Maurice A. Mufson, MD**
Director of Virology, Hektoen Institute for Medical Research of Cook County Hospital, Chicago



Dr. Mufson



Dr. Brunell

10:20 AM Viral Exanthems and Rubella ..... **Philip A. Brunell, MD**
Assistant Professor of Pediatrics, New York University School of Medicine

11:00 AM Coffee break

11:20 AM Hepatitis ..... **Friedrich W. Deinhardt, MD**
Chairman, Department of Microbiology, Presbyterian–St. Luke's Hospital, Chicago

12:00 NOON Question and Answer Period

12:30 PM Lunch



Dr. Deinhardt

1:25 PM Introductory Remarks ..... **Neal Nathanson, MD**
Moderator
Professor of Epidemiology, The Johns Hopkins University School of Hygiene and Public Health

1:30 PM Respiratory Viral Diseases ..... **H. Brandis Marsh, MD**
Medical Officer, Respiratory Virology Unit, Laboratory Division, National Communicable Disease Center



Dr. Marsh

2:10 PM CNS-Enteric Viruses ..... **Richard T. Johnson, MD**
Eisenhower Professor of Neurology, Associate Professor of Microbiology and Director of Neurovirology Laboratories, The Johns Hopkins University School of Medicine

2:50 PM Intermission

3:00 PM Laboratory Diagnosis of Viral Diseases ..... **J. Mehsen Joseph, PhD**
Chief, Division of Virology, Bureau of Laboratories, Maryland State Department of Health

3:40 PM Antiviral Agents ..... **Robert M. Friedman, MD**
Senior Investigator, Laboratory of Pathology, National Cancer Institute



Dr. Friedman

4:20 PM Question and Answer Period

5:00 PM Adjourn

Note: Each 30-minute presentation will be concluded by a 10-minute question and answer period.

Detach and return this reservation form to: Symposium Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral St., Baltimore, Md. 21201

Name .....

Address .....
Street City Zip

I enclose check for $..... ($5 per person INCLUDING lunch) *
Make check payable to Medical and Chirurgical Faculty
All reservations should be received before October 31. Tickets will be held at registration desk.

* House officers and medical students, $2.50 (please indicate)



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

Pro-Banthine® Helps...

propantheline bromide

...REVEAL the ulcer

...HEAL the ulcer

The efficiency of Pro-Banthine—its favorable balance of therapeutic and secondary actions—has been thoroughly tested and observed. This quality has been demonstrated surgically, roentgenographically, cinegastroscopically and, above all, clinically.

When physicians needed to relax the restless duodenum for the recently refined technic of hypotonic duodenography they logically turned to Pro-Banthine.

For years Pro-Banthine has been the most widely used anticholinergic medication for calming the gastrointestinal tract—for suppressing secretion, prolonging the action of antacids and providing the proper environment for healing peptic ulcers.

These established therapeutic actions make Pro-Banthine particularly useful in:

- peptic ulcer
- gastritis
- diverticulitis
- irritable colon
- biliary dyskinesia
- functional hypermotility

We wish to thank Drs. Marcia K. Bilbao, Louis H. Frische, Josef Rösch and Charles T. Dotter for this exceptionally graphic example of hypotonic duodenography.

Contraindications: Glaucoma, severe cardiac disease.

Precautions: Since varying degrees of urinary hesitancy may occur in elderly men with prostatic hypertrophy, this should be watched for in such patients until they have gained some experience with the drug. Although never reported, theoretically a curare-like action may occur with possible loss of voluntary muscle control. Such patients should receive prompt and continuing artificial respiration until the drug effect has been exhausted.

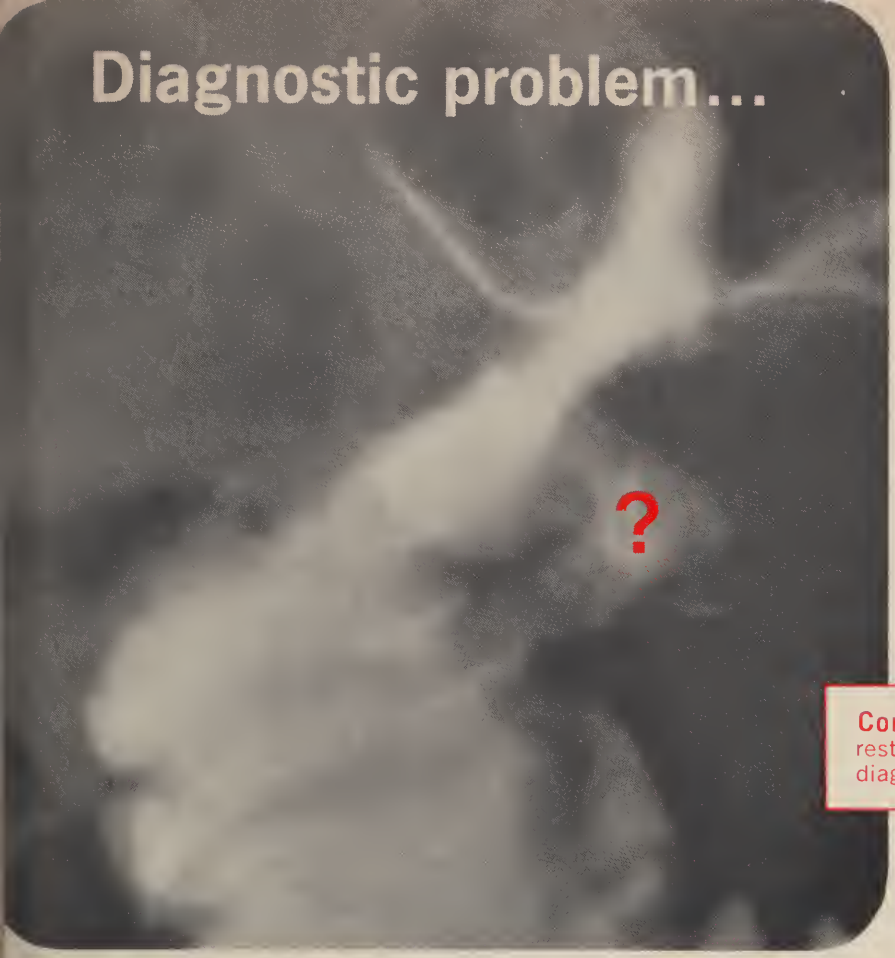
Side Effects: The more common side effects, in order of incidence, are xerostomia, mydriasis, hesitancy of urination and gastric fullness.

Dosage: The maximal dosage tolerated without excessive side effects is usually the most effective. For most adult patients this will be four to six 15-mg. tablets daily in divided doses. In severe conditions as many as two 15-mg. tablets four to six times daily may be required. Pro-Banthine (brand of propantheline bromide) is supplied as tablets of 15 mg., as prolonged-acting tablets of 30 mg. and, for parenteral use, as serum-type vials of 30 mg. The parenteral dose should be adjusted to the patient's requirement and may be up to 30 mg. or more every six hours, intramuscularly or intravenously.

98

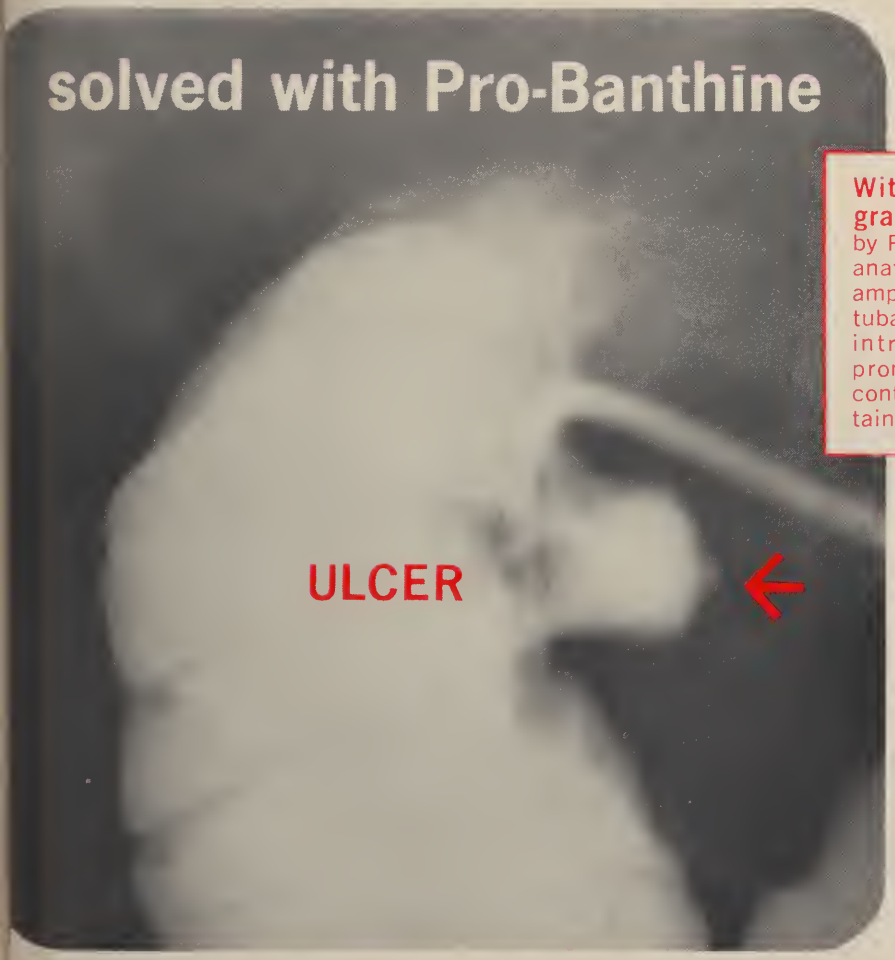
SEARLE *Research in the Service of Medicine*

Diagnostic problem...



Conventional x-rays of the restless duodenum are often diagnostically indefinite.

solved with Pro-Banthine



With hypotonic duodenography duodenal calm induced by Pro-Banthine permits clear anatomic appraisal. In this example the duodenum was intubated. Pro-Banthine, 60 mg. intramuscularly, produced prompt aperistalsis. Double contrast visualization was obtained with barium and air.

What's Polycillin® (ampicillin trihydrate) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg. and 500 mg. capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL
BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201



Highway Deaths, Natural and Traumatic

SUSAN P. BAKER, MPH
Department of Public Health Administration
Johns Hopkins School of Hygiene and Public Health

At the Third Triennial Congress of the International Association for Accident and Traffic Medicine, **Jorgen Voigt,** from the University Institute of Forensic Medicine in Denmark, reported a study of road traffic deaths from natural causes. The 189 cases, which occurred over a 13-year period, included 83 automobile drivers in addition to bicyclists and motorcyclists.

Most of the deaths were attributed to coronary sclerosis and other cardiac disorders. Although 57% of the automobile drivers died before they had time to react, no other persons were killed or seriously injured; only two received slight injuries. The author concluded that "drivers in recognized or unrecognized danger of dying suddenly do not present any serious hazard to road safety."

Donald C. Pelz and **Stanley H. Schuman,** of the Highway Safety Research Institute at the University of Michigan, studied over 700 young male drivers in an effort to understand their high accident and violation rates. They found that accidents and violations increased from age 16 to age 20, then declined. Admission of risk-taking activity, such as running yellow lights and exceeding the speed limit, roughly paralleled the age-associated rise and fall in accident rate. Teen-agers were reluctant to drive after drinking, but the practice increased steadily up to age 22 and remained high at least through age 44. The accident rate per mile was highest in the young drivers who were driving the least, suggesting that experience contributes significantly to mastery of the driving task.

In an investigation of 104 motor-vehicle casualty accidents, **George W. Brown,** of the University of Iowa, noted that 71% of the drivers were less than 25 years old. Most of the driver-related factors which contributed to the crashes in the study were associated with speed, alcohol, and poor attitude. However, driver factors comprised only 19% of all contributing factors. The prevalent belief that 85% of all crashes are due to driver error stems from the fact that the National Safety Council's standard reporting form lists only 12 possible "contributing circumstances", 10 of them driver-related.

Half of the factors which contributed to the crashes in this study were vehicle-related. Worn and overloaded tires, inadequate vision associated with vehicle design and configuration, and misalignment of front wheels comprised about three quarters of the vehicle-related factors. Hostile vehicle interiors and bumpers, seemingly designed for maximal injury production, were frequently indicted as sources of injury. Small imported cars were disproportionately represented among both single- and multi-vehicle collisions.

The author expressed concern at the great disparity in the sizes of vehicles which are permitted to drive in common traffic patterns; in the discrepancy between posted speed limits and the speeds for which many highways were designed, and in the failure to correlate "no passing" zones with minimum safe passing distances. He concluded that our highway transportation system has failed and the resulting threat to the health of the nation is great enough that major political and social decisions are needed.

In Sweden, as in the United States and many other countries, official statistics on traffic accidents and injuries are based upon police reports. **Jan Thorsen** and **Jens Sande,** from the National Council on Road Safety Research in Stockholm, reported on 2,424 hospital inpatients who had been injured in traffic accidents. Only 581 of these inpatients had been reported by the police as "seriously injured." An additional 536 were reported as "slightly injured." As a result, less than half of all persons whose injuries necessitated hospitalization were reported in the official statistics as having been injured.

Similar studies are needed here in the United States. Planning for emergency and inpatient care of accident victims should be based upon more complete and explicit information than that which is currently available from police statistics. It may not be realistic to expect more precise information from members of the police force, whose work at the scene of an accident involves extrication of the injured, supervision of their removal to hospitals, control of traffic flow, and collection of testimony from witnesses. However, adequate planning of emergency facilities requires that available sources of injury statistics be evaluated and improved, if necessary, before they are used as a basis for decisions.



From the Subcommittee on Traffic Safety of the Medical and Chirurgical Faculty of the State of Maryland

For elderly patients in need of a mild tranquilizer consider **Tybatran®**

brand of tybamate

(When you consult the Prescribing Information you may agree it makes good sense)



PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS


SOC · MED · & CHIRURG · TERRÆ MARIÆ · SIGILL · MENSE · JUNII · A · D · 1799 · & LIBERT · AMERIC · 23 to
INSTITUT · ΠΟΛΛΩΝ ΑΝΤΑΞΙΟΣ ΑΝΗΡ ΠΟΛΛΩΝ

Death from Narcotics Use

Baltimore City, 1963 through 1968

EDWARD F. WILSON, MD
Assistant Medical Examiner, State of Maryland
Instructor in Pathology
University of Maryland School of Medicine

RUSSELL S. FISHER, MD
Chief Medical Examiner, State of Maryland
Professor of Forensic Pathology
University of Maryland School of Medicine

BALTIMORE city, during 1968, experienced a staggering increase over past years in the number of deaths attributed directly to the use of narcotics. New York,[1] Philadelphia,[2] and Miami [3] experienced similar increases. The purpose of this report is to document various parameters of Baltimore's increase.

Under the Maryland State Post Mortem Examiner's Law [4] any death which is the result, wholly or in part, of narcotics use is a Medical Examiner's case. Every death attributed to the use of narcotics in Baltimore city is autopsied at the Office of the Chief Medical Examiner, and the toxicology necessary to identify and quantitate the naturally occurring and synthetic narcotics in the body fluids and tissues is performed in its laboratory.

As soon as the cause of death is determined, the medical examiner completes the death certificate.[5, 6] The cause of death is also recorded in the daily log maintained by the medical examiners' secretaries. Each "narcotic" death in the log books from 1963 through 1968 was reviewed. After review, one case (69003) was excluded: It was an historically confusing and chemically undocumented suicidal ingestion of methadone.

Table I shows narcotics deaths tabulated yearly by race and sex. The city's white and Negro populations are also recorded in the table. It can be seen that the number of narcotics deaths from 1963 through 1966 averaged approximately eight per year. In 1967, narcotics deaths numbered 17, more than twice the 1963 through 1966 average. In 1968 narcotics deaths totalled 47, approximately three times the number in 1967.[7]

TABLE I: Narcotics Deaths by Race and Sex

BALTIMORE CITY'S POPULATION (in thousands)

	1963	1964	1965	1966	1967	1968
White	570	560	548	538	524	517
Negro	354	362	370	376	386	392
TOTALS:	924	922	918	914	910	909

RACE AND SEX OF NARCOTICS DEATHS

	1963	1964	1965	1966	1967	1968
N/M	6	7	0	1	12	29
W/M	3	2	4	4	3	12
N/F	0	0	0	2	2	5
W/F	0	1	1	0	0	1
TOTALS:	9	10	5	7	17	47

In Table II it can be seen that with the exception of one death, the increase in narcotics deaths from 1967 to 1968 was confined to the ages 12 through 29. The increase in the number of narcotics deaths in the 15 through 19 age group was proportionally greater than in the 20 through 29 age group.

TABLE II: Narcotics Deaths by Age Group

AGE (years)	1963	1964	1965	1966	1967	1968
15-19	0	0	2	1	3	14
20-29	5	8	3	3	12	30
30-39	3	2	0	2	2	3
40+	1	0	0	1	0	0
TOTALS:	9	10	5	7	17	47

In comparing 1967 to 1968, Table III shows that Negro men and Negro women accounted for over two thirds of the increase in total narcotics deaths and for over three fourths of the increase in teenage narcotics deaths.

During 1967 the number of narcotics deaths per consecutive quarter numbered four, six, three, and four. In 1968 the number of narcotics deaths increased in each consecutive quarter from one death during January through March, to 11 deaths and 14 deaths during the second and third quarters respectively, and reached a total of 21 deaths during October through December

In the first quarter of 1969 the number of narcotics deaths totaled 12.

TABLE III: Race, Sex, and Age Group of Narcotics Deaths

Race, sex age group	1963	1964	1965	1966	1967	1968	
N/M 15-19	0	0	0	0	3	10	
N/M 20-29	3	6	0	0	8	16	
N/M 30-39	3	1	0	1	1	3	
N/M 40+	0	0	0	0	0	0	
W/M 15-19	0	0	1	0	0	1	(12 yrs)
W/M 20-29	2	1	3	2	3	11	
W/M 30-39	0	1	0	1	0	0	
W/M 40+	1	0	0	1	0	0	
N/F 15-19	0	0	0	1	0	2	
N/F 20-29	0	0	0	1	1	3	
N/F 30-39	0	0	0	0	1	0	
N/F 40+	0	0	0	0	0	0	
W/F 15-19	0	0	1	0	0	1	
W/F 20-29	0	1	0	0	0	0	
W/F 30-39	0	0	0	0	0	0	
W/F 40+	0	0	0	0	0	0	
YEARLY TOTAL	9	10	5	7	17	47	

It is believed, probably correctly, that the recent increase in the number of narcotics deaths reflects directly the recent increase in the number of narcotics users.[1] The increase in arrests for narcotics violations in Baltimore city is shown in Table IV. There was a marked increase in narcotics arrests from 1966 to 1967, and a slight decrease in narcotics arrests in 1968 compared to 1967.[8]

TABLE IV: Age Group of Persons Arrested on Narcotic Charges by Baltimore City Police (including those released without having been formally charged) [8]

AGE (YEARS)	1966			1967			1968		
	a	b	c	a	b	c	a	b	c
11-19	24	77	156	61	225	344	71	70	320
20-29	90	15	185	212	31	324	225	63	420
30-39	39	4	56	87	0	111	60	7	95
40-49	18	3	23	31	2	40	27	6	45
50-59	1	0	4	5	0	6	7	2	9
60+	0	0	0	1	0	3	1	0	1
TOTALS	172	99	424	397	258	828	391	148	890
YEARLY TOTALS:		695			1483			1429	

a. Possession/sale of opium, cocaine and their derivatives (morphine, heroin, and codeine)

b. Possession/sale of synthetic narcotics/manufactured narcotics which can cause true addiction (demerol and methadone) c. Violation of narcotics drug laws

From the DRUG USED FROM ARREST EXPERIENCE statistics shown in Table V can be seen the increase in arrests for the sale or possession of narcotics.

The toxicology laboratory at the Office of the Chief Medical Examiner has documented two narcotics deaths involving methadone in Baltimore city. In one, a trace of methadone was found and no other narcotics. In the other death, a trace of methadone was found along with a trace of cocaine.

In 1969, cough syrup was added to the DRUG USED FROM ARREST EXPERIENCE category. Recently reported from Pittsburgh was the first death in the United States attributed to ingestion of non-prescription codeine-type cough syrup.[9]

TABLE V: Drugs Used from Arrest Experience of Baltimore City Police [8]

DRUGS	1967	1968	JAN.-MAY 1969
Sale of Heroin	60	60	26
Possession of Heroin	291	206	236
Sale of Cocaine	2	6	1
Possession of Cocaine	7	41	53
Sale of Methadone	0	26	11
Possession of Methadone	10	141	104
Possession of Morphine	1	4	9
Possession of Dilaudid	4	3	0
Possession of Codeine	5	1	6
Possession of Meperdine	0	1	0
Possession of Cough Syrup	—	—	15
YEARLY TOTALS	380	489	226

Approximately 90% of narcotics deaths unexpectedly and suddenly follow intravenous injection of narcotics, usually heroin.[1] The improvised syringes, needles, empty and full packets of heroin mixtures, spoon or bottle cap cookers containing a small cotton wad, matches, and crude tourniquets are often found in close proximity to the deceased user. Occasionally, loss of consciousness or death occurred so rapidly that the tourniquet was still in place on the arm and the needle stuck in the skin, the syringe partially filled with blood mixed with residual heroin solution, the blood indicative of perforation of a vein by the needle.[10] Overdosage with heroin, contained in the mixture injected, accounts for most of the unexpected and sudden deaths, but probably not for all.

The problem of variable heroin concentration of the mixture injected, the contribution of the non-narcotic portion of the narcotic mixture injected, and the frequency and strength of the narcotics injections taken shortly before death and in the previous period must be considered, as well as the factor of tolerance for heroin which may have been lost during a period of abstinence. What might have been a safe dose prior to abstinence, may prove to be a lethal dose for an addict abruptly resuming his habit.[10]

However, certain unexpected and sudden narcotics deaths are not the result of narcotics overdose, but are probably the result of an idiosyncratic reaction to the injected material. Where death was so rapid that the needle and syringe were still in the skin of the deceased, toxicologic examination of body fluids and tissues has demonstrated only the presence of alkaloid, not overdosage. In deaths immediately following intravenous narcotic injection, rarely is there no evidence of alkaloid in the body fluids or tissues.[10]

The following cases are illustrative of unexpected and sudden death following intravenous narcotic injection. Noteworthy is the fact that six of these men had been released recently from a penal institution and one was actually serving time in a penal institution.

Case #1 (Anne Arundel) *: This 42-year-old Negro man entered the Maryland House of Correction on June 29, 1966. The subject returned from the Maryland Correctional Camp Center to the Maryland House of Correction at 7:30 PM on April 14, 1968. He appeared to be under the influence of drugs or drink and was placed under medical observation. He was "observed" hourly until 8:10 AM on April 15, 1968, at which time he was found dead.

Autopsy disclosed old needle puncture scars in each antecubital fossa and one fresh needle puncture mark in the left antecubital fossa. Toxicology revealed negative blood alcohol, 8.0 mg% morphine in the bile and 0.2 mg% morphine in the urine.

** Not included in Baltimore city narcotics deaths statistics.*

Case #2 (69504): This 16-year-old Negro man was home on a three-day pass from the Maryland Training School. He went to bed at 1:00 PM on August 12, 1968. At 10:00 PM that same day, there was no response to attempts to awaken him. He was taken to the hospital where he survived for two days. Autopsy, at the Office of the Chief Medical Examiner, disclosed lobar pneumonia as the immediate cause of death. Autopsy also disclosed old needle puncture scars in the left antecubital fossa, and a recent or fresh needle puncture mark in each antecubital fossa. Toxicology revealed a trace of methadone and a trace of nalline in the bile.

Case #3 (57763): This 24-year-old Negro man entered the Maryland House of Correction on December 23, 1963, and was released on June 18, 1964, at 8:40 AM. He was found dead in a park on June 19, 1964, at 7:05 AM. Autopsy disclosed old needle

puncture scars and one fresh needle puncture mark in the right antecubital fossa. Toxicology revealed negative blood alcohol, negative blood barbiturate, 0.5 mg% morphine in the bile, a trace of morphine in the urine, and a trace of codeine in the urine and bile.

Case #4 (57840): This 39-year-old Negro man served a year for robbery in Maryland House of Correction and was released on July 6, 1964. He was found dead on July 8, 1964, at 8:25 AM. "We cooked up the stuff, I took off first; I put it in the vein of my left arm, then Ben (the deceased) used a belt as a tourniquet for one of his legs . . . and shot heroin. After Ben took off, he sat still for a moment, and then suddenly he jerked and fell forward. . . . I felt for a heart beat and I also felt his pulse and it seemed to be weak." The witness left the scene and it was not certain how long the deceased survived at the scene of death. Autopsy disclosed old needle puncture scars in each antecubital fossa, both forearms, the right lower leg, and a fresh needle puncture mark in the medial aspect of the left lower leg. Toxicology revealed negative blood alcohol, 5.6 mg.% morphine in the bile, and a trace of morphine in the urine.

Case #5 (68572): Because of narcotics violations, this 19-year-old white man had been confined for a few months at the Hagerstown Correctional Institute. He was released from the Hagerstown Correctional Institute at 3:00 PM on April 8, 1968, and arrived home at 6:00 PM on the same date. His mother stated that he remained at home until she left for work at 8:00 AM on April 10, 1968. Her son was found dead on his back alongside tire tracks in the woods, approximately 35 feet from a road on April 12, 1968, at 6:30 AM. Autopsy disclosed old needle puncture scars in each antecubital fossa, three recent needle puncture marks and a fresh needle puncture mark in the left antecubital fossa. Toxicology revealed negative blood alcohol. Narcotics were not detected in the urine or bile.

Case #6 (55409): This 24-year-old Negro man was imprisoned for robbery on March 26, 1963, and released on August 13, 1963. On August 17 at 7:45 PM he was found dead on a couch in the living room of friends. There were an eyedropper-type syringe, two needles, a spoon with a burned bottom, and an empty glassine envelope on the bureau in the adjacent bedroom. Autopsy disclosed only old needle puncture scars in the left antecubital fossa. Toxicology revealed negative blood alcohol, negative blood barbiturate, negative urine amphetamine, 4.0 mg% morphine in the bile, and 0.4 mg% morphine in the urine.

Case #7 (66008): This 25-year-old Negro man entered the House of Correction February 15, 1967, and escaped on May 8, 1967. On May 13, 1967, at 9:00 PM, he asked to use the toilet at a gas station. At 10:30 PM he was found dead on the bathroom floor. Beside the body were the "works." Autopsy disclosed old needle puncture scars in each antecubital fossa and fresh needle puncture marks in each forearm. Toxicology revealed negative blood alcohol, negative bile narcotics, a trace of codeine in the urine, a trace of morphine in the urine, quinine in the syringe, and heroin and quinine in the bottle cap.

Case #8 (69264): On July 14, 1967, at 6:50 AM, this 20-year-old Negro man was found on the ground in back of a house. Autopsy disclosed numerous old needle puncture scars in each antecubital fossa. There was a fresh needle puncture mark in the right antecubital fossa. Toxicology revealed negative blood alcohol, a trace of methadone in the urine, and a trace of cocaine in the urine. There were no narcotics in the bile.

Case #9 (70957): On January 30, 1969, this 19-year-old Negro man was found dead, fully clothed, sitting upright in an easy chair with a syringe attached to a needle sticking in the skin of the left antecubital fossa. A nylon stocking tourniquet was around the left upper arm. Tweezers and a bottle cap were on the right arm of the chair. Capsules with white powder were found on the bureau in the adjacent bedroom. Autopsy disclosed old needle puncture scars in each forearm. In the left antecubital fossa there was a 20 gauge needle attached to an eyedropper with a rubber bulb top. The eyedropper was partially filled with blood. Toxicology revealed negative blood alcohol; 0.1 mg% morphine in the urine; quinine in the urine; 0.6 mg% morphine in the bile; heroin, morphine, and quinine in the skin of the injection site; heroin, morphine, and quinine in the syringe; heroin and quinine in the bottle cap; heroin and quinine in the packet and a trace of quinine in a capsule.

REFERENCES

1. *The Sun,* Baltimore, August 15, 1968, p. 2.
2. *The Sun,* Baltimore, September 18, 1968, p. 1.
3. Blackbourne, MD, Assistant Medical Examiner, Dade County, Fla., personal communication.
4. Annotated Code of Maryland (1957 ed), Article 22.
5. Siegel, Henry; Helpern, Milton; and Ehrenreich, Theodore: The Diagnosis of Death from Intravenous Narcoticism, *J For Sci* **11**:1-16 (Jan) 1966.
6. Burton, John F, et al: Mainliners and Blue Velvet, *J For Sci* **10**:466-472 (Oct) 1965.
7. Rogerson, Betty: Annual Vital Statistics Report for Maryland, Md. State Dept. of Health, Div. of Biostatistics (1963-1968).
8. Kohler, Captain William, Vice Control Section, and Jasper, Lt. Walter T., Narcotic Unit, Personal Communication.
9. Winek, Charles L: *NEJM* **280**:840 (April 10) 1969.
10. Helpern, Milton; and Rho, Yong-Myun: Deaths from Narcoticism in New York City, *NY State J Med* **66**:2401-2402 (Sept 15) 1966.

The authors wish to extend their appreciation to Donna Fedeli.

Sacculotomy in the Treatment of Meniere's Disease

The treatment of Meniere's disease has long been a therapeutic enigma as testified to by the many and varied methods in use today.

In this paper, the features of Meniere's disease will be discussed, with a recent surgical procedure reported that has yielded gratifying results in six patients.

N. EDWARD NACHLAS, MD
Assistant Professor
Johns Hopkins School of Medicine

MERVIN TRAIL, MD
Resident in Otolaryngology
Johns Hopkins Hospital

DONN DUNCAN, MD
Resident in Otolaryngology
Johns Hopkins Hospital

Historical Background

Prosper Meniere, in 1861, presented a paper describing the triad of symptoms that were taken to constitute the disease (or syndrome) that was to bear his name: tinnitus, hearing loss, and vertigo. He was the first to correlate these symptoms with inner ear pathology, as reports of similar cases prior to that time were diagnosed as a form of "apoplectiform cerebral congestion." It is of interest to note that the primary purpose of Meniere's paper was to establish the relation of the inner ear to the symptoms described, rather than to describe a definite disease entity.

Etiology and Pathology

The basic pathology in Meniere's disease is gross distention of the endolymphatic system with degenerative changes in Corti's organ. This endolymphatic hydropexis usually extends throughout the endolymphatic system, but may occur in the sacculocochlear region. Since the term Meniere's disease describes a symptom complex, the specific condition with this pathogenesis may more appropriately be called hydropexis of the labyrinth and cochlea. The supposed causes of Meniere's disease are quite varied. Many factors have been suggested as being primary or contributing causes including allergy, metabolic disturbance, histamine sensitivity, focal sepsis, psychosomatic factors, vitamin deficiency, and inflammation. Present day literature would tend to support a hypothesis based on vasomotor imbalance with abnormality either in the overproduction, or the lack of absorption, of the endolymph.

Clinical History

Three predominant subjective symptoms compose the classic triad; vertigo, tinnitus, and decrease in auditory acuity.

The cardinal, and most distressing symptom to the patient is rotatory vertigo. Characteristically, its presentation is explosive and the patient frequently does not have a warning aura. A relationship to position, activity, or time period is not evident. In some, a sensation of fullness or pressure in the involved ear may precede an acute attack.

The vertiginous episodes are usually relatively short, and are measured in minutes or hours, not in days or weeks as so often characterizes intracranial disease. The severity of the attack is variable, but generally is described as moderate to marked and is often accompanied by loss of spatial orientation and falling toward the affected ear. Nausea and vomiting frequently accompany the attack. The patient is, however, free of these symptoms between attacks.

In contrast, tinnitus may be present constantly, immediately preceding, during, or following an attack. It is described as a roaring, non-pulsing, low-pitched type of tinnitus. This symptom may be so slight as to be overlooked by the patient in the early part of the disease, but as it progresses, it becomes a more prominent feature, although rarely a disabling one.

Hearing loss in Meniere's disease is of the perceptual or neural type and varies from one attack to another. During initial attacks, the patient will complain of a decrease in hearing acuity, frequently with return to normal thresholds during the recovery period. With subsequent episodes, the hearing acuity becomes more impaired. This phenomenon is repeated with each attack and the result is a moderate to severe hearing impairment in the untreated patient. Early, the low frequencies are affected, but gradual involvement of all frequencies is the usual picture.

Since Meniere's disease is regarded as a unilateral process, the above symptoms are localized usually in one ear, although 10% of the patients manifest bilateral involvement.

Physical Examination

Unless the patient is seen during an acute crisis, physical examination will yield little information aside from detectable hearing loss. If seen during an acute episode, some or all of the following may be present:

- Nystagmus—Present only during an acute attack. The jerky movement of the eye is directed away from the affected ear.
- Spatial disorientation—Signs of severe disorder in equilibrium with staggering and falling toward the affected ear when attempting to walk.
- A tendency for the patient to lie down in a rather rigid, fixed position with the affected ear down.
- Absence of convulsion or pain.
- Preservation of consciousness during the attack.
- Nausea, often followed by vomiting.

Audiometric and Vestibular Testing

Visual examination of the ear usually reveals normal findings unless there is a coexisting pathologic state. Tuning fork tests (512 cycles per second) will be consistent with a neural hearing loss, ie, air conduction will be greater than bone conduction. The Weber test will lateralize to the uninvolved ear if there is more than minimal loss.

Recruitment, an abnormal sensitivity to increased loudness, is often found in patients with Meniere's disease. This may be clinically tested with tuning forks (preferably a 512 or 1024 cycles per second) by comparing the hearing in both ears after hitting the forks softly and again after hitting them harder. In the former, the patient will state he hears the tone better in the uninvolved ear, while in the latter maneuver he is likely to be unable to differentiate between the two ears, or even state he hears better in the affected ear; ie, hyperrecruitment. This phenomenon remains unexplained, but is associated with hearing losses that occur primarily in the cochlea. This phenomenon is also demonstrated by more sophisticated tests including loudness balance tests, short increment sensitivity index (SISI), and Bekesy audiometric tests.

Diplacusis binauralis dysharmonica is another finding frequently existing in Meniere's disease. The patient complains of hearing the same sound as a different pitch in the two ears, usually the higher pitch being heard in the involved ear.

Loss of speech discrimination is a frequent complaint and a consistent audiometric finding. The discrimination score is much lower than one would expect from the pure tone audiogram. Patients complain that speech is audible, but not understandable.

Specific audiometric testing can verify all the impressions in addition to accurately assessing the degree of hearing loss.

Vestibular testing is of value in diagnosis as the responses to calorics often are hypoactive. However, even in severe cases the caloric study may be normal. As mentioned previously, nystagmus is present only during an acute attack.

Treatment

Successful control of 85% to 90% of Meniere's disease patients can be obtained by medical therapy, though this is rarely completely satisfactory. There is no specific medical therapy for hydropexis.

Medical treatment falls into two areas; the acute vertiginous episode, and the interim periods.

Treatment of the acute vertiginous episodes is largely supportive and symptomatic. The patient is given antiemetic and antimotion-sickness medications, in addition to sedatives, to reduce the anxiety that invariably accompanies the attacks. Intravenous histamine often gives prompt relief of the symptoms.

Therapy in an interim period is directed at forestalling and reducing the severity of future attacks. The patient should be placed on a moderate low salt diet and a restricted fluid intake. Supplemental therapy with histamine and vasodilators has been advocated; the dosage and timing vary, however. The difficulty of properly evaluating medical treatment is apparent when we realize that spontaneous remissions often occur after symptom-free periods and may last as long as ten years without treatment. Two drugs often used in this condition,

betahistine hydrochloride *(SERC)* and Lipoflavanid Complex, are under investigation by the FDA at the present time.

Surgical therapy is reserved for those patients who are not controlled by vigorous medical management. These individuals suffer from frequent attacks that are often incapacitating and may threaten loss of employment. Severe emotional disturbance may play an important role as the patient is often fearful of another attack, and indeed the patient often may appear psychoneurotic as a result.

Surgical procedures, like medical regimens, have changed frequently due to lack of uniformly successful results with any specific approach. Posterior fossa sectioning of the vestibular nerve, which carried a relatively high morbidity and occasionally a mortality rate of significance, is rarely done today. Neurosurgical section of portions of the vermis are occasionally done.

Approaches to the inner ear with the operating microscope have vaulted the otologic surgeon to the forefront in the surgical management of this disease. Various operations to destroy the labyrinth by electrocautery, ultrasound, and cryosurgery, as well as endolymphatic shunt and vestibular nerve section through an otologic approach, give relief. The majority of these procedures are performed to relieve the vertigo. The destructive procedures usually destroy the hearing as well as the labyrinthine function. In addition, some of the procedures are long and technically difficult, and produce undesirable morbid reactions.

Discussion

Fick, in 1964, reported a series of 50 patients with severe vertigo, all but three suffered from Meniere's disease. In a recent report on over 100 patients, he confirmed his initial findings. He described the method of endolymphatic decompression used in the following cases.

Fick stated that in 60% of his patients, vertigo disappeared and in an additional 16%, hearing was restored to normal with no recurrence of tinnitus. This was an absolute case rate of 76% for vertigo, the main indication for the operation. Ten percent more related an improvement in the vertigo.

The surgical procedure is done under local anesthesia. A tympanomeatal flap is raised (Illust. I, a) and by removing a portion of the posterior superior bone of the canal the following are visualized: (Illust. II) the incudo stapedial joint, the pyramid, the stapedial tendon and the footplate of the stapes (Illust. I, b, c, and Illust. II). With a perforator, an opening is made in the footplate (anterior) and the saccule is decompressed. A light dressing is inserted to keep the tympanomeatal flap in place.

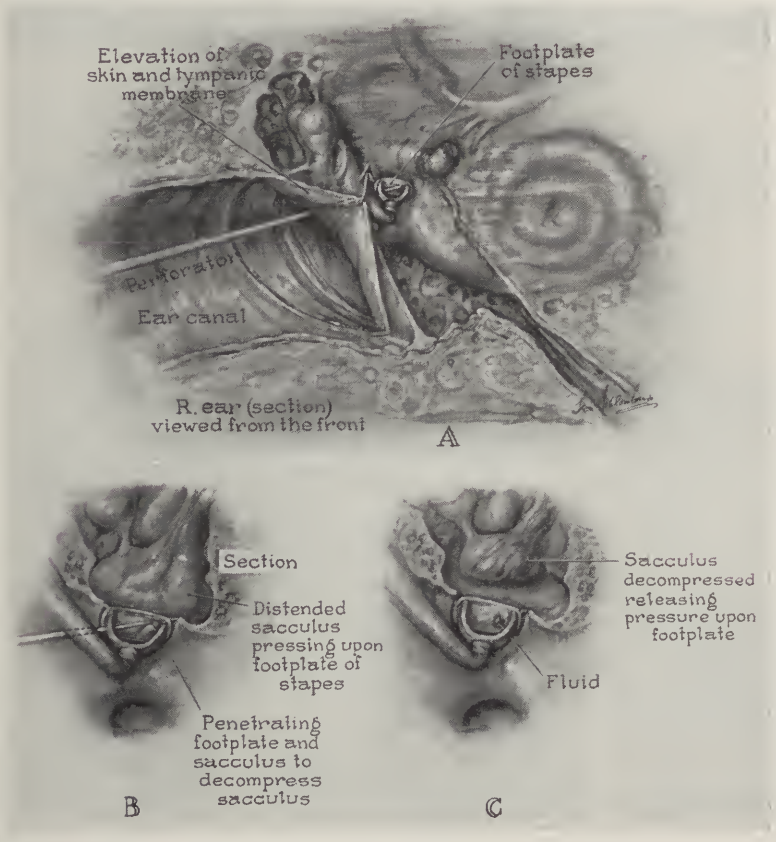


Illustration I

A. Elevation of tympanomeatal flap

B. Perforator penetrating footplate of stapes

C. Decompression of saccule by escape of endolymph

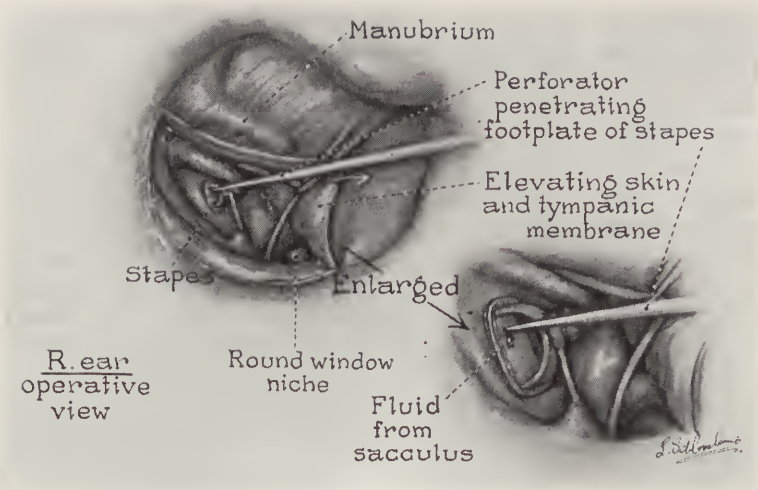


Illustration II

Perforator of footplate of stapes (anterior) to decompress the saccule.

Case Reports

Case 1: W. G., 60-year-old man with severe recurrent episodes of vertigo accompanied by nausea and vomiting for about four months duration—

The patient was treated medically during this four-month period for Meniere's disease. His symptoms progressed and his hearing deteriorated to the degree of a total loss of clinically serviceable hearing. Sacculotomy was performed 12/13/66 and the patient was relieved of all the symptoms except the hearing loss which remained unchanged. He has remained free of symptoms.

Case 2: W. S., 40-year-old man with a six-year history of episodic vertigo, spatial disorientation, nausea, vomiting, tinnitus, and progressive hearing loss in the left ear—

The neurological evaluation was reported as normal; audiogram showed non-functioning left ear; vestibular studies were consistent with a hypofunctioning labyrinth. Sacculotomy on 9/1/65 brought about a prompt relief of the vertigo.

Case 3: A. L., 67-year-old woman with severe tinnitus and dizziness, but without nausea or vomiting. There was moderate hearing loss—

The patient had a history of emotional disorder some years prior to onset of present neurologic complaints. Sacculotomy on 4/12/66 yielded improvements of symptoms although the patient continued to complain on rare occasions of fleeting episodes of dizziness. There was also some improvement in hearing.

Case 4: N. O., 68-year-old man with severe intermittent vertigo, tinnitus, and profound hearing loss—

Audiometric and vestibular studies performed on this patient were consistent with the symptoms of Meniere's disease. Sacculotomy on 9/23/65 brought prompt relief of symptoms. The hearing was unchanged.

Case 5: S. F., 54-year-old man with clinical evidence of Meniere's disease confirmed by audiometric and vestibular testing—

The patient had total loss of hearing in the involved ear. Sacculotomy was done on 7/13/67. Follow-up showed patient free of all vertigo and marked reduction in the tinnitus. The hearing remained unchanged.

Case 6: P. B., 40-year-old man with incapacitating vertigo and severe hearing loss in the left ear—

Sacculotomy on 12/23/65 provided prompt relief of vertigo and moderate improvement in the hearing. Patient remained well for two years and then suffered mild attacks of vertigo with diminution in the hearing. The vertigo was relieved promptly with medical therapy.

We do not intend to infer that this procedure offers a complete answer to the surgical treatment of hydropexis. Although the number of cases presented here are few, this direct and relatively simple surgical approach appears to have merit in selected cases of Meniere's disease.

Summary

There are several advantages to this approach which the authors feel make it a treatment of choice: (1) The surgical approach is relatively simple and can be performed using local anesthetic agents; (2) the operative time is short, usually 30-45 minutes; (3) relief is almost immediate; (4) the post-operative period is likewise brief, 2-3 days; (5) return to normal routines can generally be expected within a week's time; (6) destruction of the labyrinth is not performed, thus allowing the patient to qualify for repeat fenestration or other surgical procedures.

REFERENCES

1. Fick, I. A.: Decompression of the Labyrinth, *Archives Otol.* **79:**447, 1964.
2. Fick, I. A.: Sacculotomy for Hydrops, *Laryngoscope,* **75:**1539, 1965.
3. House, W. F.: Subarachnoid Shunt for Drainage of Endolymphatic Hydrops, *Laryngoscope,* **72:**713, 1962.
4. Shambaugh, G.: Surgery of the Ear, W. B. Saunders 1967.

The process of wound healing has a high biological priority. Most wounds heal completely within a relatively short period of time, in spite of preoperative starvation, infection, or increased force against their tensile strength.[1-3] A few wounds do not heal, but disrupt. Many factors play a role in the disruption of a laparotomy wound: increased intra-abdominal pressure, metabolic state of the patient, wound infection, and surgical technique. Occasionally, disruption occurs in a young, healthy patient in an otherwise uncomplicated postoperative course after elective surgery; it's as if the healing process has suffered an arrest.

This paper is a comparison of the frequency of wound disruption after abdominal operations in St. Joseph Hospital with that reported in the literature, and an evaluation of the predisposing causes in an effort to prevent this complication.

Wound Disruption After Abdominal Laparotomies

ROBERTO O. FERRER, MD
St. Joseph Hospital

Clinical Material

During the two-year period of this study, ending December 31, 1967, 2,058 laparotomies were performed at St. Joseph Hospital. In 37 of these cases, wound disruption occurred, a 1.8% incidence. (Excluded from this study were 347 appendectomies, done through McBurney's muscle-splitting incision, because there was no reported disruption following this type of incision; and repair of inguinal hernias.)

The incidence of abdominal wound disruption, reported in the literature, is from 1.5% to 3%.[2,5]

Twenty-two men and 15 women—a ratio of 1.5:1—were included in this study. This is a lower predominance of men compared to other series: Lehman et al[4] found the ratio to be 2.8:1; and Efron's ratio was 2.2:1.[2] This lower incidence of wound disruption in women has been explained by a more relaxed abdominal wall due to pregnancy, predominant chest breathing, and less physical activity. Most of the women in this study (80%) had had pregnancies; two of them had wound disruption after the laparotomy for cesarean section.

The age range was from 21 to 84 years. (Little pediatric surgery is done in this hospital which may account for the absence of such cases in the pediatric age group.) Sixteen of the patients, 43%, were more than 50 years old; usually there is a higher incidence of wound disruption in the older age group, but no explanation has been found for the predominance of younger people in this study.

The duration of the operation did not seem to be related to this complication of abdominal surgery.

The operative time ranged from less than one hour to more than four—most of the procedures were completed in less than three hours. General anesthesia was administered in all except two cesarean sections that were done under spinal anesthesia.

Wound disruption may happen any time during the postoperative period. In this series, the earliest instance occurred on the third postoperative day, and the latest was on the 28th. The disruptions were recognized usually between the 5th and 12th postoperative day—32 patients, 86%, fell into this range.

It is an accepted phenomenon that disruption before the 5th day cannot be blamed on poor wound healing;[1,2] this is "mechanical disruption" because the disrupting force on the wound is greater than the tensile strength of the sutures and the tissues in which they are placed. Early disruption reveals some technical fault in the suture material, or the method of closure. In this study, five patients had wound disruptions before the 5th day. One patient had delirium tremens and the sutures were seen cutting through the fascia at the closure of evisceration. Another patient suffered from cough and acute gastric dilatation; and the other three had severe coughs. Retention sutures had not been used on any of these five patients. A layered closure had been executed using chromic catgut in the peritoneum and fascia in one case, chromic catgut in the peritoneum and non-absorbable material in the fascia in the other four.

Predisposing Causes of Wound Disruption

Wound Infection: Infection of the disrupted wound was found in five patients, 13%; but cultures of the wounds were taken only if the infection was clinically evident.

Mechanical Causes: In this group all the mechanisms which produce increased intra-abdominal pressure were observed: cough, vomiting, retching, hiccoughs, and abdominal distention. Such causes were encountered in most of the cases of wound disruption. Twenty-five, 67%, had one or more of these complications. Obesity may be a cause of intra-abdominal pressure and in the case of two of the patients in the study, obesity may have been one of the additional complications. One of these patients, a 35-year-old man, also had mild coughing in the postoperative period; and the other, a 21-year-old woman, had mild vomiting during the first two postoperative days.

Metabolic Causes: The evaluation of the metabolic factors is sometimes a question of clinical judgment: The routine laboratory determinations do not always give a true picture of the metabolic state. For example, Localio et al[5] have demonstrated that the level of tissue proteins is not always in direct proportion to plasma-protein concentration. The study conducted at the hospital showed that depletion of protein in the fascia is an important factor in the cause of wound disruption. In many of Localio's cases, the plasma protein was within normal limits. The better known metabolic factors that may be involved in the causes of disruption are anemia, hypoproteinemia, and hypovitaminosis C.

Chronic anemia is a recognized factor of poor wound healing.[1,6,7] It also indicates hypoproteinemia.[7] Four patients in the series had hemoglobin below 10 gm%. They were bleeding from the gastrointestinal tract—two had peptic ulcers, and the other two had esophageal varices due to liver cirrhosis. Hypoproteinemia was present in the two patients with liver cirrhosis. The relationship of hypoproteinemia to the disruptions was not evaluated in this study because routine determinations of plasma proteins were not done in either the preoperative work-up or after the disruption occurred.

Saslov and Dunphy have demonstrated that steroids inhibit wound healing when started in large doses before the operation, but that they do not interfere with the healing of the disrupted wound when it is resutured.[8] One patient in this series was under corticoid therapy because of rheumatoid arthritis. At the time of surgery, his tissues were found to be very friable. No retention sutures were used in this case. The wound disrupted on the 8th postoperative day; it healed after being resutured.

Ascorbic acid is necessary for fibroblasty in the healing wound: The concentration of ascorbic acid in the leucocytes is in direct relationship with healing.[1] Many wounds heal in spite of low plasma concentrations of vitamin C, but they do not heal at all when the leucocytes are depleted of this vitamin, such as occurs in far-advanced scurvy. Hartzell et al have found that a drop in ascorbic acid levels occurs in plasma after a major operation, and during infections.[3] They also found low levels in patients with malignant tumors of the gastrointestinal tract, and peptic ulceration. Lehman et al have found a 4.6% incidence of laparotomy wound disruption in patients having carcinoma of the gastrointestinal tract: In the same series, they reported only 2.1% in patients without this malignancy.[4] Hypoproteinemia, hypovitaminosis C, and cachexia are more frequent in the cancer patients, which explains this higher incidence.

Mortality

Four patients, 11% of the series of 37, died following wound disruptions. One had a right hemicolectomy for carcinoma. She was 84 years old and developed pneumonia. The immediate cause of death was found at autopsy to be acute myocardial infarction.

Another patient who died had a partial gastrectomy for a bleeding duodenal diverticulum. She developed wound disruption and dehiscence of the duodenal

stump. The wound was resutured and the duodenal stump was drained. She suffered a second disruption and died 12 days after it was again resutured. The terminal cause was pneumonia.

The third patient in this group was a cirrhotic who sustained a partial gastrectomy for a bleeding duodenal ulcer. He developed delirium tremens after surgery, and eviscerated in the 3rd postoperative day. He died ten days after this complication developed. Liver cirrhosis and ascites were found in the autopsy.

The fourth patient was another cirrhotic who had an exploratory laparotomy because of jaundice. He had emphysema and severe hypoproteinemia (albumin 2.6%, globulin 3.3%). He went into hepatic coma, had wound disruption on the 16th postoperative day, and died five days later. Aspiration pneumonia was the immediate cause of death.

The underlying disease and physical condition of the patient is usually responsible for the outcome of the wound disruption. In none of the above cases was the disruption the immediate cause of death.

Surgical Procedure

In Table 1 are grouped the various surgical procedures and the diseases for which they were undertaken. Only the main procedures are tabulated. Incidental appendectomies; oophorectomies in cases of hysterectomy; vagotomy in cases of gastrectomy, and repair of hiatal hernia are not counted.

Table 1: Surgical Procedures

Hysterectomy (1 cancer, 7 fibroids)	8
Cholecystectomy	6
Partial gastrectomy (ulcer)	5
Repair of esophageal hiatal hernia	5
Exploratory laparotomy (gunshot wound, liver biopsy)	2
Hemicolectomy (cancer)	2
Cesarean section	2
Release of adhesions	1
Release of volvulus of the sigmoid	1
Hemostasia of torn mesenteric vessels	1
Appendectomy	1
Cholecysto-jejuno anastomosis (cancer of the pancreas)	1
Oophorosapingectomy	1
Excision of entero cutaneous fistula and partial resection of small bowel (Crohn's disease)	1

In this series there is an unusually high incidence of disruption after gynecological operations. All of them but one had been done through a lower midline incision and the laparotomies were closed in layers with chromic catgut. In one year, 1967, 513 "pelvic laparotomies" were done on women, all through a lower midline incision. Almost every one of them was closed with chromic catgut. There were seven wound disruptions in this group—an incidence of 1.2%. This is not much lower than the general incidence of 1.8% for all the laparotomies in two years (1966 and 1967). Less incidence of disruptions for the lower midline incision is generally reported. In this series the difference is not very significant.

Surgical Technique

Different types of incisions and suture techniques have been used in these cases; they are classified in Tables 2 and 3. One of the transverse incisions was a right subcostal for cholecystectomy, the other was a bilateral subcostal for repair of hiatal hernia and cholecystectomy. In this hospital most surgeons favor the right subcostal incision for cholecystectomy. Only one disruption occurred through this incision compared to five after cholecystectomy through a right paramedial incision.

Table 2: Type of incision

Upper midline	4
Lower midline	10
Upper left paramedian	5
Lower left paramedian	1
Upper and lower left paramedian	2
Upper right paramedian	9
Lower right paramedian	1
Upper and lower right paramedian	3
Transverse	2

Table 3: Type of closure

Continuous chromic catgut in the peritoneum, interrupted chromic catgut in the fascia	16
The same as above plus retention sutures	3
Continuous catgut (chromic or plain) in the peritoneum, non-absorbable, interrupted sutures in the fascia	18

In the three patients who had a layered closure of chromic catgut, supplemented with retention sutures (#2 nylon), the disruption occurred on the 6th, 10th, and 11th postoperative days with the retention sutures in place.

Closure of the Disrupted Wound

It has been demonstrated by Saslov and Dunphy that the healing of the disrupted and resutured wound follows an accelerated pattern.[8] The onset of the fibroplasty seems to be earlier without the usual latent period. In 32 cases, the wounds were resutured using through and through retention sutures of #2 nylon. In the other five cases, they were closed in layers, supplemented with retention sutures in one. The resutured wound healed well in 33 cases. No information of the degree of healing was available in the patients who died.

Conclusion

Abdominal wound disruption remains a postoperative complication in spite of the knowledge about wound healing and the predisposing causes of the

disruption. It is usually found to be a combination of causes which leads to the complication. Prevention has to start during the preoperative work-up of the patient, with correction of anemia, hypoproteinemia, hypovitaminosis C, improvement of ventilation, and treatment of infection in patients with chronic lung disease. Anemia is readily recognized and easily corrected by transfusions. Hypoproteinemia is difficult to overcome by parenteral administration of plasma or concentrated albumin, but a trial has to be done in patients who have hypoproteinemia and edema because they are highly susceptible to wound disruption. Low levels of ascorbic acid should be suspected in all undernourished patients and in those with gastrointestinal malignancy. Administration of ascorbic acid has to be routine in these patients.

It is difficult to evaluate the importance of the surgical technique because it has been shown that wound disruption occurs with every kind of suture material and with every suture technique. However, there are enough reports in the literature to show that laparotomies closed with vertical "figure eight" sutures in one layer have a lower incidence of disruption.[4-10] In high-risk patients, that is, those with chronic lung disease, gastrointestinal malignancy, cirrhosis, edema, anemia, etc., the use of retention sutures may avert the disruption (and should this occur, prevent the evisceration). When retention sutures are used, the time to remove them is after a firm healing ridge is palpable along the line of incision.[11]

Summary

Thirty-seven wound disruptions occurring in 2,058 laparotomies in a period of two years are analyzed. Many factors may play a role in this complication; increased intra-abdominal pressure is the most constant. Different types of suture materials used in a layered closure do not make a difference in the incidence of disruption. It is suggested that the correction of metabolic deficiencies, the use of vertical "figure eight" sutures, and prevention of intra-abdominal pressure will reduce this postoperative complication.

REFERENCES

1. Moore, F. D.: Metabolic Care of the Surgical Patient. Chapter 5, Philadelphia, Saunders, 1959.
2. Efron, G.: Abdominal wound disruption. *Lancet* **1**:1287, 1965.
3. Hartzell, J. B., Winfield, James and Irvin, J. S.: Plasma Vitamin C and serum protein levels in wound disruption. *JAMA* **116**:669, 1941.
4. Lehman, Jr., A. J., Cross, S. C., and Partington, P. F.: Prevention of abdominal wound disruption. *SGO* **126**:1235, 1968.
5. Localio, S. A., et al.: Tissue protein depletion: factor in wound disruption. *SGO*, **86**:107, 1948.
6. Bains, J. W., et al. An effect of chromic anemia on wound tensile strength, correlation with blood volume, total red cell blood volume and proteins. *Ann. Surgery* **164**:243, 1966.
7. Lyons, C. et al.: The surgical significance of Hbg. deficiency in Protein depletion. *JAMA* **135**:9, 1947.
8. Saslov, F. D., and Dunphy, J. E.: The healing of the disrupted and resutured wound. *Surgery* **36**:362, 1954.
9. Sedwick, C. E. and Sullivan, J. T.: Abdominal wound disruption: Analysis of 217 cases. *Surg. Clinics of N. A.*, June, 1957.
10. McCallum, G. T. and Link, R. F.: The effect of closure techniques on abdominal disruption. *SGO* **119**:75, 1964.
11. Pareira, M.: Prediction of wound disruption by the use of healing ridge. *SGO* **115**:72, 1962.

The incidence of moderate to severe pulmonary fibrosis following radiotherapy for mediastinal Hodgkin's disease was 68% in 21 patients. The corresponding incidence in 20 patients with bronchogenic carcinoma was 75%. Severe symptoms occurred in 10% of the patients with Hodgkin's disease one year after radiotherapy, while the incidence of severe symptoms among the patients with bronchogenic carcinoma was 30%. No patients died due to causes arising from the pulmonary fibrosis.

Pulmonary Fibrosis Following Radiotherapy For Bronchogenic Carcinoma and Hodgkin's Disease*

H. GUNTER SEYDEL, MD, MS
Chief, Department of Radiology
American Oncologic Hospital
Philadelphia

J. MAUN, MD
Resident in Radiology
University of Maryland Hospital

Pulmonary fibrosis has long been recognized as a possible complication of radiotherapy, and recent reviews of this sequela of irradiation have been published by Deeley,[1] Smith,[2] and Whitfield et al.[3] The unusual incidence of severe reactions at relatively low doses in patients with lymphomas has been reported by Taylor,[4] Smith,[5] and Wiernick.[6] Holt [7] also implied that the pulmonary reaction in patients with what he called "leukemic and allied disorders" can be expected to be more severe than in other patients.

To evaluate whether the incidence of pulmonary fibrosis is indeed higher in patients treated for Hodgkin's disease than in a group of similarly treated patients with bronchogenic carcinoma, we are reporting here on the incidence of this finding in 21 patients with Hodgkin's disease and 20 patients with bronchogenic carcinoma, all of whom survived at least one year following radiotherapy to the mediastinum.

Methods and Material

Twenty-one patients with Hodgkin's disease of the mediastinum received radiation therapy with midline tumor doses of 3500 to 4000 rads, using parallel opposing portals without correcting for lung absorption. Most of the patients underwent treatment using a cobalt 60 irradiator. The treatment time was approximately four weeks. Chest X-rays were obtained before treatment, and three months, six months, and one year after treatment.

The 20 patients with bronchogenic carcinoma received a tumor dose of 4000 to 4500 rads to the entire mediastinum and the primary tumor by parallel opposing portals, and an added dose of 1500 to 2000 rads was usually given to the involved nodes and primary tumor using rotational therapy. No lung correction factors were applied. The treatment was given at approximately 1000 rads per week. These patients also had chest X-rays before treatment, and three months, six months, and one year after therapy.

From the large number of patients receiving radiation therapy for bronchogenic carcinoma, the majority had to be excluded because of one of the following reasons: prominent masses which could not be distinguished as either recurrent or persistent tumor, or pulmonary fibrosis; postoperative changes which did not allow accurate evaluation of the lung parenchyma regarding the presence or absence of pulmonary fibrosis; pleural fluid obscuring part of the lung parenchyma or producing secondary changes; atelectasis which either persisted or occurred following radiotherapy, and again prohibited the accurate evaluation of the pulmonary parenchyma.

The chest X-rays were graded as either no evidence of pulmonary fibrosis, minimal, moderate or severe fibrosis. "No evidence of fibrosis" indicated the fact that there had been no appreciable change in the appearance of the broncho-vascular markings or pulmonary parenchyma from the pre-treatment

* *Presented at the Meeting of the Maryland Radiological Society, Baltimore, Maryland, March 21, 1968. Supported by the National Institute of Health, grant # CA 06518-03.*

film. If there was a discernible increase in the pulmonary markings in the treated area, this was called minimal fibrosis. In patients with moderate fibrosis, there was evidence of opacification of part of the lung parenchyma, usually fluffy in nature and containing definite areas of aeration within the opacified areas, sometimes also associated with a slight loss of volume of the affected lung. Severe fibrosis was roentgenographically evident by dense opacification with coalescence of the above mentioned fluffy areas, usually no areas of aeration within the densely opacified area, and frequently with partial atelectasis, loss of volume of the affected lung, elevation and later tenting of the diaphragm. The pulmonary fibrosis was always limited to the irradiated lung.

To correlate these changes on the chest X-ray with the symptomatology in the patient, the patient's symptoms were graded as absent, mild, and severe. Mild symptoms consisted of a slight cough and slight shortness of breath, which did not require medication other than a cough remedy. As a rule, these patients did not suffer enough disability to require them to take time off from work. Severe symptoms were demonstrated by shortness of breath at rest or during mild exertion, and by coughing and elevation of temperature. They, on the other hand, were usually associated with a more severe disability requiring a decrease in workload. These patients usually required treatment with a combination of antibiotics and steroids, in addition to the use of expectorants or cough preparations.

Results

Table 1 shows the results of chest X-ray examinations in patients with Hodgkin's disease. It becomes evident that the incidence of the moderate and severe changes increased with time after treatment, and the maximum of the severe changes was present in the twelve-month group. Only 8% of the patients never showed any evidence of pulmonary fibrosis, although an additional 23% demonstrated only minimal changes. On the other hand, in correlating the symptomatology, it was evident that at one year after treatment the symptoms usually subsided, requiring little or no medication. No fatalities have been attributed to the fibrosis. These patients, however, do have a greater susceptibility to pulmonary infections. Some shortness of breath during moderate to severe exertion also may persist.

TABLE 1: Patients with Hodgkin's Disease

	3 mo.	6 mo.	12 mo.
Pulmonary Fibrosis, Minimal	25%	30%	23%
Pulmonary Fibrosis, Moderate	37%	38%	38%
Pulmonary Fibrosis, Severe	12%	23%	30%
Mild Symptoms	25%	20%	15%
Severe Symptoms	5%	20%	10%

The results in patients with bronchogenic carcinoma are shown in Table 2. Here, there is a fairly rapid increase in the percentage of patients with moderate to severe evidence of pulmonary fibrosis on chest X-ray, and this reaches a maximum at 12 months. Table 2 also shows that the symptomatology in these patients increased significantly toward the 12th month. However, in none of these patients was there any evidence that recurrent tumor was responsible for the symptoms at the time.

TABLE 2: Patients with Bronchogenic Carcinoma

	3 mo.	6 mo.	12 mo.
Pulmonary Fibrosis, Minimal	40%	25%	17%
Pulmonary Fibrosis, Moderate	20%	50%	50%
Pulmonary Fibrosis, Severe	13%	6%	25%
Mild Symptoms	25%	30%	30%
Severe Symptoms	0%	25%	30%

Discussion

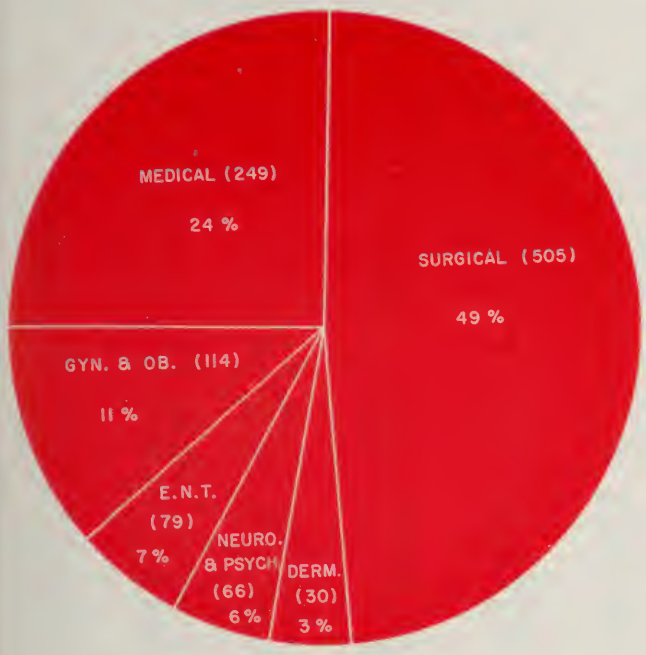
Comparison of the figures presented reveals that the patients with Hodgkin's disease seemed to develop pulmonary fibrosis slightly earlier than those with bronchogenic carcinoma, although the over-all incidence was approximately the same. Only 8% of both groups did not show any evidence of pulmonary fibrosis. However, one year after irradiation, the symptoms referable to the pulmonary fibrosis were significantly more severe and more prevalent in the patients treated for bronchogenic carcinoma. It is difficult to exclude that some of the patients were not already developing some degree of recurrence and that some of their symptoms were not referable to this, however, the previously enumerated steps were taken to exclude this for the patients under investigation. Also, as described, there are some differences in dose and volume of irradiation between the two groups of patients. Furthermore, the two groups are not entirely comparable because of the age incident and natural history of the diseases.

An important finding is that, even though symptoms are present and some morbidity is associated with pulmonary fibrosis, no patients treated for Hodgkin's disease died of this sequela of radiotherapy. Because of the irreversible nature of the fibrotic changes in the lung, extreme care should be taken to protect the normal lung as much as possible during irradiation.

REFERENCES

1. Deeley, Thomas J.: The Effect of Radiation on the Lungs in the Treatment of Carcinoma of the Bronchus, *Clin Radiol* **11**:33-39, 1960.
2. Smith, J. C.: Radiation Pneumonitis: A Review, *Am Rev Resp Dis* **87**:647-655, 1963.
3. Whitfield, A. G. W.; Bond, W. H.; and Kunkler, P. B.: Radiation Damage to Thoracic Tissues, *Thorax* **18**:371-380, 1963.
4. Taylor, R. M.: The Somatic Effects of Radiation, *Canad Med Ass J* **86**:521-525, 1962.
5. Smith, J. C.: Radiation Pneumonitis: Case Report of Bilateral Reaction After Unilateral Irradiation, *Am Rev Resp Dis* **89**:264-269, 1964.
6. Wiernick, G.: Radiation Pneumonitis Following a Low Dose of Cobalt Teletherapy, *Brit J Radiol* **38**:312-314, 1965.
7. Holt, J. A. G.: Letter to the Editor, *Brit J Radiol* **18**:638, 1965.

Emergency Room Problems of An 'Inner Core' City Hospital



An In-Depth Analysis of the Emergency Department, Bon Secours Hospital

WILLIAM E. BEAVEN, MD
Director, Emergency Department
Bon Secours Hospital

JUAN F. SORDO, MD
Assistant Director, Emergency Department
Bon Secours Hospital

PATRICIA WHELTLE, RN
Head Nurse, Emergency Department
Bon Secours Hospital

For the compilation of most of the statistical material used in this article, the authors wish to express appreciation to Mrs. Joyce A. Tucker, Director of Ward Secretaries, Bon Secours Hospital.

In 1958 the United States Public Health Service [1] was startled to find that the annual number of patient visits to hospital emergency rooms across the country had increased to 17 million, an 81% increase over 1954. By 1967, this figure reached 44 million. Sanford,[2] in an exhaustive study of outpatient facilities in hospitals in the state, calls this trend in escalating outpatient visits a fact of life requiring continual analysis in order to determine a way to cope with it.

Typical of this trend in rapidly expanding emergency services are the public and privately owned hospitals of metropolitan Baltimore. Recently compiled statistics, published by the Hospital Council of Maryland, Inc.,[3] shows that the annual number of patients visiting the 22 Baltimore hospital emergency rooms increased from 340,000 in 1960 to over 582,000 in 1967, a percentage increase of 71.4, or approximately 10% per year (Table I).

Table 1 shows that many of the more rapidly expanding emergency services are occurring in hospitals that have recently moved from a downtown location to the suburbs (St. Joseph and Sinai). Interestingly, in some of the most centrally located areas of the city, where facilities for medical care for the poor are limited, the number of emergency room patients in hospitals serving these areas (Maryland General, Provident, and Mercy) has scarcely increased at all, while the number of patients in two hospitals (South Baltimore, and Franklin Square) has actually decreased over the seven-year period of study.

TABLE 1: Annual Emergency Room Visits, All Baltimore Hospitals * (1960-1967)

	1960	1961	1962	1963	1964	1965	1966	1967
1. Baltimore City	29,835	31,882	22,951	22,798	30,048	34,326	47,080	54,635
2. Baltimore County	—	—	—	—	—	—	9,301	11,022
3. Baltimore E.N.T.	—	1,360	3,553	2,942	3,095	3,136	3,152	3,074
4. Bon Secours	5,628	6,091	8,762	11,314	13,297	15,019	17,516	23,056
5. Church Home	10,705	11,860	11,235	12,120	12,645	14,269	16,259	16,654
6. Franklin Square	13,651	13,443	11,965	10,373	8,759	7,528	7,471	7,161
7. G.B.M.C.	—	—	—	—	3,012	4,376	2,821	3,908
8. Hospital for Women	—	144	1,226	1,371	—	—	—	—
9. Johns Hopkins	70,395	73,521	84,343	79,905	84,320	99,255	106,931	114,365
10. Kernan	—	—	—	—	—	—	16	87
11. Lutheran	19,326	20,007	20,195	20,149	18,832	23,478	22,558	23,509
12. Maryland General	7,298	7,949	7,261	7,111	7,715	7,450	8,256	8,892
13. Mercy	18,183	18,146	19,468	19,863	19,876	19,978	21,128	20,335
14. North Arundel	—	—	—	—	—	—	6,537	23,654
15. Presbyterian E.N.T.	—	263	556	1,002	—	—	—	—
16. Provident	17,653	16,035	16,159	20,211	21,671	19,475	18,099	19,096
17. St. Agnes	17,692	19,579	24,381	29,781	33,948	36,894	37,484	39,444
18. St. Joseph	15,595	14,425	14,479	16,429	18,318	17,847	17,920	32,743
19. Sinai	25,638	30,969	35,937	40,408	44,520	49,214	50,968	78,635
20. South Baltimore	20,571	20,056	19,501	20,103	20,036	19,233	17,985	17,714
21. Union Memorial	31,149	31,761	32,565	34,576	39,321	38,387	34,604	36,456
22. University	36,579	37,040	36,166	36,281	40,096	41,524	50,299	48,178
TOTALS:	339,898	354,531	370,703	386,736	419,509	451,389	496,384	582,618

** The Hospital Council of Maryland, Inc. Annual Statistical Reports: 1960-1967*

In sharp contrast, however, is the situation in the emergency service of Bon Secours Hospital, located in the very "inner core" of west Baltimore. Here the number of emergency room patients has climbed from 5,600 in 1960 to over 23,000 in 1967, a percentage gain of over 450% or 65% per year. Although 11 other Baltimore hospitals have a greater annual number of patients, the growth rate for Bon Secours is the fastest for not only all hospitals in the city of Baltimore, but for the entire state of Maryland as well.[3] In other words, the growth rate of the emergency service at Bon Secours is five to six times the national rate, as calculated by the United States Public Health Service.[1] An annual patient count of well over 50,000 is expected by 1972.

However, two hospitals that now care for 195,000 people in west Baltimore, (Franklin Square and Provident), will soon be torn down and moved to the suburbs. Presumably, the emergency room at Bon Secours, 'The Hospital That Elected To Stay', will inherit an additional 26,000 patients, those now being treated by these two other hospitals. If this does occur, the annual patient load at Bon Secours' emergency room could reach 75,000 by 1972.

To effectively meet the needs of the growing number of outpatients, it is necesasry to understand the services and equipment available to deal with the problem, as well as the characteristics of the population being served by such care. To accomplish this, two analyses of current emergency room activities at Bon Secours were made. The first is presented in this article.

Materials and Methods

The Bon Secours Hospital is a completely accredited, full service general hospital for adults and children. It is a privately owned hospital for short-term patients, under the auspices of the Sisters of Bon Secours. The hospital opened in 1919 and a new addition was built in 1954. The hospital contains 254 beds with a newborn nursery of 48 beds. It is located in west Baltimore and has a fairly constant inpatient service averaging 9,200 admissions per year.

The present emergency room, containing six stretchers and three treatment rooms, is fully equipped to handle all medical, surgical, obstetrical, and pediatric emergencies. Part of the new $7 million building program includes a more modern up-to-date emergency room, planned for occupancy in 1972.

Prior to 1967, the emergency room was completely staffed by the hospital's interns and residents; ie, one intern served in the emergency room each month, with the resident staff on call for consultation. Because of an increasing patient load, this system proved inadequate. So, in October, 1967, the hospital obtained a group of five licensed physicians to provide continual medical care in the emergency room, seven days a week. These physicians, all general surgeons, have formed a partnership and are contracted by the hospital to carry on a group practice within the emergency room as independent contractors, on a fee-for-service basis. In April, 1969, the medical staff of Bon Secours gave the emergency room departmental status, with representation on the hospital executive committee.

This study covered 1,043 patient visits to the emergency service over a two-week period (September 22 to October 5, 1968). Excluded from the study were patient visits for circulation cast checks, prescription refills, Tine and other test readings, routine injections requested by the clinic to be given on weekends, etc. Repeat (follow-up) visits are not allowed in the emergency room; none were recorded.

Included in this study are data obtained from the standard Emergency Service Record Form, consisting of information on the patient's age, sex, race, time of arrival to the emergency room, classification of the complaint, family physician, diagnosis (impression) as recorded by the physician on duty, and the source of payment for emergency services rendered. Finally, a list of minor procedures performed on these patients during the two-week period is presented.

Since many of the demographic and other socioeconomic characteristics of the above patient population were not recorded on the Emergency Service Record Form, supplementary patient interviews using detailed questionnaires are being considered for future studies. Data from these interview/questionnaires will be tabulated and transferred to standard IBM cards for analysis.

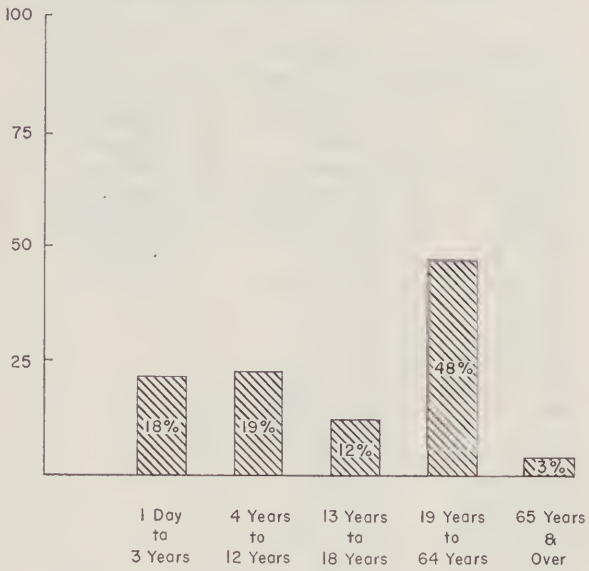
Results of the Study Analysis of the Patients

Sex: Of the 1,043 patients visiting the emergency room during the two-week period of study, 490 were men, 553 were women. A standard statistical deviation of error can partially account for the larger percentage of women in the outpatient facility. In addition, 36 of the women were pregnant and 18 of them had cases of acute salpingitis, mostly venereal in origin. Men with venereal disease were most frequently referred to other health clinics in the city, and were not registered at the emergency room desk.

Race: Three hundred forty-nine (33.5%) of the patients visiting the emergency room were white, 694 (66.5%) were Negro.

Age: Figure 1 shows the patient sample by age groups. Eighteen percent (184) of the patients were from one day to three years old, while 19% (195) were from four to 12 years of age. The total number of pediatric patients in the sample group was 379, or 37%. In the adolescent age group, (13 to 18), there were 128 patients, representing 12% of the sample. Most of the patients were adults between the ages 19 and 64 (504 or 48%). Only three percent of all patients were over the age of 65.

Fig. 1: Patient Sample by Age Groups



Time of Arrival at the Emergency Room: Eleven per cent (117) of the patients arrived between 12 AM and 8 AM. Forty per cent (418) arrived between 8 AM and 4 PM, and the remaining 49% (508 patients) arrived between 4 PM and 12 AM.

Family physician: Meaningful statistics on the number of patients having family physicians were difficult to obtain. Some patients denied having a personal physician, when in fact they may have had several. On the other hand, many patients gave the names of physicians who were either deceased, had long since been out of practice, or were completely inaccessible to the patient. Nevertheless, 381 (36%) patients stated that they did have a family physician and 592 (57%) did not have one. Probably 75% to 80% of the patients had no real patient-physician relationship. There are two possible explanations: A large number of the people visiting the facility are poor; and, many of the family physicians have moved their practices away from the Bon Secours area in recent years.

Conditions Treated in the Emergency Room

Table 3 lists the conditions that were treated in the emergency room. Of the 1,043 patients that were admitted, 505 (49%) had surgical conditions, 249 (24%) had medical conditions, and of the remaining

289 (27%), 114 (11%) had gynecological and obstetrical problems; 79 (7%) otorhinolarynological; 66 (6%) neurological and psychiatrical; and 30 (3%) had dermatological conditions. Since this study was undertaken in early fall, numerous patients suffering from upper respiratory infections were observed. In fact, if the number of these cases, 76, is combined with the cases of tonsillitis (48), pharyngitis (14), and otitis (9) seen, it can be calculated that these diseases constituted approximately 14% of the total number of diagnoses made for the entire patient sample. Most of these conditions, with the exception of the gynecological and obstetrical cases, occurred in the pediatric patients.

TABLE 3: Primary Diagnoses Recorded for 1,043 Admissions to the Emergency Room September 22-October 5, 1968 (14 days)

Surgical: 505		Medical: 249		Gyn. & Ob.: 114		Neuro. & Psych.: 66		E.N.T.: 79		Dermatological: 30	
Contusion	102	Up. Res. Inf.	76	Pregnancy	36	Alcoholism	14	Tonsillitis	48	Dermatitis	12
Laceration	95	G. Enteritis	49	Cystitis	19	Anxiety	12	Pharyngitis	14	Psoriasis	2
Sprain	46	Asthma	28	Salpingitis	18	Epilepsy	8	Otitis	9	Impetigo	1
Head Injury	44	Bronchitis	21	Pyelitis	13	Headache	7	Sinusitis	3	Stasis Ulc.	1
Abrasion	39	M. Ischemia	9	Menorrhagia	7	Psychosis	6	Epistaxis	3	Misc.	14
Fracture	24	Mes. Adenitis	8	Ovarian Cyst	6	Drug Over:		Laryngitis	2		
Dog Bite	24	H.C.V.D.	8	Abortion	6	1. Acc.	6	Misc.	0		
Infec. Wound	20	Influenza	7	Dysmenorr.	5	2. Inten.	3				
Hematoma	18	Pneumonitis	5	Misc.	4	Misc.	10				
Abscess	13	C.H.F.	4								
Insect Bite	12	C.V.A.	3								
Foreign Body	11	M. Infarct	3								
Punc. Wound	15	Card. Arrest	2								
Burn	7	Peptic Ulcer	2								
Cyst	6	Diabetes M.	2								
Gun Shot Wd.	5	Arthritis	2								
Concussion	4	Anemia	2								
Cholecystitis	4	Pleurisy	2								
Appendicitis	2	Pancreatitis	1								
Amputation	1	Gout	1								
Dislocation	1	Rubella	1								
Misc.	12	Varicella	1								
		Bursitis	4								
		Misc.	8								

Table 4 lists the numbers and types of minor procedures performed on the patient sample during the two-week period. Of the 95 recorded lacerations, only 77 required suturing. In addition, 24 fractures were treated.

TABLE 4: Minor Procedures Performed on 1,043 Patients Admitted to the ER

Type of Procedure	Numbers
Suturing of Laceration	77
Incision & Drainage of Abscess	17
Reduction of Fracture (Closed)	8
Application of Plaster Cast	13
Excision of Foreign Body	11
Debridement of Wound	21
Reduction of Dislocation	1
X-ray Examinations	211

Classification of the Conditions Treated

A study of the degree of urgency of the patient's condition, as evaluated by the physician on duty revealed: Conditions of 52 patients (5%) were considered extremely urgent; those of 417 (40%) were evaluated as emergent; and 574 (55%) were considered nonemergent.

Extremely urgent conditions are those that demand immediate attention, ie, gross hemorrhage, acute poisoning, cardiac emergencies, respiratory distress, etc. In such conditions in children under age, the law waivers the need for immediate parental consent, and imposes a definite obligation on the part of the physician to begin treatment without delay. Emergent conditions, while not life-threatening, require immediate treatment to avoid inevitable disability or irreversible consequences. Most, but certainly not all, are surgical in nature; many require immediate hospitalization. Nonemergent conditions are treated only because other health facilities are not available at the time, and in the opinion of the examining physician, require only limited therapy.

Post Emergency Room Referral

After receiving emergency care. Sixty percent (624) of the patients in this study were referred to an appropriate outpatient department clinic at Bon Secours, mostly by direct appointments. Thirty-two percent (332) of the patients were referred back to their recorded family physician, while 5% (56) of

the patients were admitted directly to the hospital. Thus, from a total of 9,200 annual in-service hospital admissions, 15% of these admissions came directly from the emergency service. Another 2% of the (25) patients were entitled to workman's compensation benefits. Four patients were transferred to other hospitals. Two patients died in the emergency room, both from cardiac arrest.

Sources of Payment for Emergency Room Service

Twenty-four percent (256) of the patients stated that they had some form of Blue Cross or Blue Shield medical insurance coverage, or both. Possibly as high as 4% of the claims forms submitted, however, were rejected: either the policy had expired or the medical condition was not covered by the particular policy in question. Furthermore, since Blue Shield insurance claims for emergency room service are valid only if the medical condition is traumatic in origin and did not exist 72 hours before treatment was sought, only approximately 10% to 12% of the entire patient sample received payment help from Blue Shield, Inc. Thirty-three percent (343) were Welfare patients entitled to full or partial medical assistance payments and 14% (142) were covered by a variety of private medical insurance policies. Two percent (17) of the patients were entitled to Medicare benefits. Twenty-two percent (225) patients had no third-party payment resources; hence, they were categorized as "cash" patients.

Conclusions

From this study, certain facts emerge. First of all, the Bon Secours Hospital emergency service is rapidly assuming a dominant role in the ambulatory health needs of west Baltimore. In addition, its function as an "accident ward" is being more and more overshadowed, and somewhat interfered with, by its use as a 24 hour-a-day "walk-in" clinic. Finally, its location within the "inner core" of the city, with its large proportion of indigent patients, is creating a considerable financial strain on the hospital.

Although a new, greatly enlarged emergency room is already being planned, it will not be completed before 1972. The number of patients is rapidly increasing, and the existing facilities may become completely inadequate long before this time.

It is certainly not too early to begin preparing for such an eventuality; other health facilities must share this patient load. With so many nonemergent patients being admitted, a closer working relationship between the emergency room and the outpatient department clinics must be established. An evening and week-end medical/pediatric outpatient service has been suggested for clinics and this step alone would relieve much of the congestion in the emergency room during these times.

Summary

1. **An in-depth analysis of the Emergency Department of Bon Secours Hospital has been undertaken.**
2. **A statistical survey of the number of patients in the emergency rooms of 22 Baltimore hospitals is presented, along with a comparative growth rate of Bon Secours.**
3. **A sample of 1,043 patients admitted to the emergency service at Bon Secours over a two-week period is analyzed for the following information: the patient's sex, race, age, time of arrival in the emergency room, family physician, diagnosis, classification of the complaint, post emergency room referral, and source of payment for services rendered.**
4. **A need for closer working arrangements with other health facilities, such as the outpatient department clinics, is established.**

"All that Bon Secours has done will be multiplied by what it now will do."

—Sister Theopane, CBS

REFERENCES

1. McGibony, J. R.: Is your emergency room ready? *Med. Ann. D.C.* **32:** 23 (1963).
2. Sanford, G. A.: The outpatient department explosion. *Md. State Med. J.* **16:** 44 (June 1967).
3. Sanford, G. A.: Information bulletin number 157, Hospital Council of Maryland, Inc., Annual Statistical Report '67 February, 1968.

your medical faculty at work

by John Sargeant
Executive Secretary

The House of Delegates in Semiannual Session met at Hershey, Pa., on Friday, September 5, 1969, and took the following action:

1. Adopted minutes of the April 9 and April 11, 1969, House of Delegates meetings;
2. Elected the following to Emeritus Membership on recommendation of the Council and the Baltimore City Medical Society:

   Jerome J. Blumberg, MD
   Warfield M. Firor, MD
   R. Carmichael Tilghman, MD

3. Elected to Honorary Membership in the Faculty, on the recommendation of the Executive Committee:

   William B. Kouwenhoven, Dr. Ingr., MD (Hon)

4. Adopted the following Standing Rule of the House:

   "A Committee chairman or the reporting member of a committee who is not a member of the House of Delegates shall have the privilege of making motions and speaking in debate in connection with the report of such committee. Others who are not members of the House of Delegates may, by a three-fourths vote, be extended the privilege of making a verbal report to the House for a time not to exceed five minutes. They may, by majority vote, be allowed to revise and extend their report for publication in the Transactions issue of the *Maryland State Medical Journal.*"

5. Adopted resolutions honoring the memory of **John M. T. Finney, Jr., MD,** Baltimore, and **Bernard O. Thomas, Sr., MD,** Frederick;
6. Accepted the Auditor's Statement for 1968;
7. Adopted various Bylaw amendments;
8. Received various Information Committee Reports.

The Executive Committee and Council in sessions held at Hershey, Pa., on Thursday, September 4, 1969, took the following actions:

Executive Committee:

1. Received and agreed to submit names for consideration of the United States Pharmacopeial Nominating Committee;
2. Approved recommendation of **Kurt Raab, MD,** Baltimore, for appointment to the Medical Advisory Board, Department of Motor Vehicles;
3. Approved a questionnaire to be used in conducting a survey on Physician Attitudes toward Nurse-Midwives with the understanding that this was not necessarily approving the conclusions reached from the survey. It is also to be understood that the results would be made available to the Faculty prior to their publication;
4. Declined to provide information as to what would be the appropriate fee per hour or per two-hour session for work of physicians in a chest clinic;
5. Authorized expenditure of staff time and underwriting other expenses in connection with a state-wide study of perinatal deaths;

6. Endorsed the project, Evaluation of Nutritional Status of Preschool Children in the U.S., as proposed by the Children's Hospital Research Foundation, Cleveland, Ohio, provided it conforms with all Maryland laws;
7. Authorized sale of two Persian rugs owned by the Faculty;
8. Redesignated the position occupied by **Mr. Joseph J. Harrison, CPA,** as Comptroller;
9. Authorized transfer of 750 shares of Elkton Bank and Trust Company from the present trustee name, All & Co., to the name of the Faculty; so as to obviate the necessity of income from this source flowing through the Trustee at a percentage cost to the Faculty;
10. Approved the Rubella Immunization Drive, with the understanding that this would be conducted as have previous similar drives, with children obtaining vaccination from private physicians, as much as possible, and those unable to obtain them through this source to be immunized in the drive through the school system;
11. Declined to approve use of the Community Health Project Fund (surplus funds from the Measles Immunization Drive) as these funds have been already committed to the Preschool Hearing and Vision Screening program; and because such use would effectively dissipate the money which it is planned to use as "seed" money for self-supporting projects;
12. Rereferred to the Medical Economics Committee for further study and report. a decision rendered in a case dealing with Usual, Customary and Reasonable Charges;
13. Designated the Subcommittee on Child Welfare as the responsible group in the Faculty to work with the Maryland Committee for Children and Youth; and agreed to inform Faculty membership of the objectives of this group, at the same time endorsing such objectives.

The Council:

1. Deferred action, until the November Council meeting, on a recommendation of the Professional Medical Services Committee, and on appointment of legal counsel for the 1970 year;
2. Adopted the following motion:

   "The Medical and Chirurgical Faculty recognizes the critical need for additional hospital facilities in Charles County and supports and endorses the efforts of the Charles County Medical Society in this regard."
3. Agreed to investigate the activities of an individual in Cumberland, Md., who has been allegedly calling herself a "cancer specialist."

The Commission on Medical Discipline is adopting Rules of Procedure which shall apply to all formal hearings before the Commission. Details may be obtained from the Commission office: 1211 Cathedral St., Baltimore, Maryland 21201.

Doctors Take Note . . . *(Continued from page 6)*

NOVEMBER 7, 1969
NEW YORK STATE ACTION FOR CLEAN AIR COMMITTEE

7th Annual Meeting: Cooper Union, 51 Astor Place, Manhattan. A panel discussion of education and training in the field of environmental health will highlight the session. The meeting is open to the public. Contact: State Committee, 105 E. 22nd Street, New York, New York 10010.

NOVEMBER 7, 1969
MARYLAND INDUSTRIAL MEDICAL ASSOCIATION/THE NATIONAL CAPITAL OCCUPATIONAL MEDICAL ASSOCIATION

Joint Meeting: Holiday Inn Downtown, 301 West Lombard Street, Baltimore, Md. The meeting will consist of a clinical session, social hour, and group dinner. For information, contact: Samuel L. Fox, MD, 1205 St. Paul St., Baltimore, Md. 21202.

NOVEMBER 10, 1969
AMERICAN COLLEGE OF CHEST PHYSICIANS

Annual Scientific Session of the Southern Chapter: Regency Hyatt House, Atlanta, Georgia. An interdisciplinary faculty will provide basic information on the principles of circulation and respiration, and the application of this information to patient care. Contact: Bradford W. Claxton, American College of Chest Physicians, 112 E. Chestnut St., Chicago, Ill. 60611.

NOVEMBER 10-14, 1969
NEW YORK UNIVERSITY SCHOOL OF MEDICINE/AMERICAN ASSOCIATION OF INDUSTRIAL NURSES

Five-day Course in Occupational Health for registered professional nurses in industry: New York University School of Medicine. Tuition—$175. Subjects include: the objectives and scope of an occupational health program; the relationship between doctor and nurse, employer and employee, and the management and the medical department; emphasis on interviewing and counselling; environmental hazards; retirement and the problems of older workers; and the legal aspects of medicine and nursing. Send applications to: Course #484, Office of the Recorder, New York University Postgraduate Medical School, 550 First Ave., New York, N.Y. 10016.

NOVEMBER 10-14, 1969
THE DEPARTMENT OF OBSTETRICS AND GYNECOLOGY, THE COLLEGE OF PHYSICIANS AND SURGEONS, COLUMBIA UNIVERSITY

Postgraduate Course in Obstetrics and Gynecology: Columbia University, New York. The course will include a refresher course in obstetric and gynecologic pathology in addition to presenting a survey of the major clinical and pathological problems of the female reproductive system. Contact: Melvin D. Yahr, MD, Associate Dean, College of Physicians and Surgeons, 630 West 168th St., New York, New York 10032.

NOVEMBER 11-14, 1969
NEW YORK UNIVERSITY MEDICAL CENTER/DEPARTMENT OF REHABILITATION MEDICINE

Full-time Course—Clinical Electrodiagnosis of Neuromuscular Diseases: Institute of Rehabilitation Medicine Research Pavillon, New York University Medical Center, 400 E. 34th Street, New York, New York 10016. For further information, contact Joseph Goodgold, MD, at the same address.

NOVEMBER 12-15, 1969
MOUND PARK HOSPITAL FOUNDATION, INC./THE UNIVERSITY OF FLORIDA COLLEGE OF MEDICINE

Postgraduate Seminar—Today's Hospital Problems: An Interdisciplinary Approach: Tides Hotel and Bath Club, Redington Beach, Florida. A $100 tuition fee must accompany each application. This program is acceptable for 20 prescribed hours by the American Academy of General Practice. For additional information, contact: M. A. Barton, MD, Director of Postgraduate Medical Education, Mound Park Hospital Foundation, St. Petersburg, Florida 33701.

NOVEMBER 13-14, 1969
THE DEPARTMENT OF GYNECOLOGY AND OBSTETRICS, WAYNE STATE UNIVERSITY SCHOOL OF MEDICINE/HARPER HOSPITAL

Symposium—Pathways of Conception—The Role of the Cervix and the Oviduct in Reproduction: Rackham Memorial Building, Detroit, Mich. The program also includes a panel discussion on "Test Tube Babies—Fact or Fancy." Contact: Alfred I. Sherman, MD, Program Chairman, Gynecology and Obstetrics, Wayne State University School of Medicine, 432 East Hancock, Detroit, Mich. 48201.

NOVEMBER 13-15, 1969
THE AMERICAN FOUNDATION OF RELIGION AND PSYCHIATRY

Convocation—The Revolution in Values—The Response of the Healer: Statler Hilton Hotel, New York City. Chairman: Hobart Lewis, President and Executive Editor of the *Reader's Digest*. Contact: Hobart Lewis, Chairman, International Convocation, 3 West 29th Street, New York, New York 10001.

NOVEMBER 13-18, 1969
AMERICAN HEART ASSOCIATION

Annual Meeting—American Heart Association: Dallas, Texas. For further information, contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Maryland 21201.

NOVEMBER 14, 1969
THE CHILDREN'S MEDICAL AND SURGICAL CENTER OF THE JOHNS HOPKINS INSTITUTIONS

Conference—Clinical Advances in Pediatrics. Practical aspects of patient care will be stressed, such as, management of jaundice in the newborn; diagnosis and treatment of anemia in childhood, and use versus abuse of antibiotics in pediatrics. The program is acceptable for 10 prescribed hours by the AAGP. For additional information, contact: Matthew Debuskey, MD, The Johns Hopkins Hospital, 601 N. Broadway, Baltimore, Maryland 21205.

NOVEMBER 14-15, 1969
NEW YORK CITY DIVISION OF THE AMERICAN CANCER SOCIETY/THE ACOG COMMITTEE ON CONTINUING EDUCATION OF GENERAL PRACTITIONERS/THE NEW YORK MEDICAL COLLEGE

Postgraduate Symposium in Gynecologic Oncology: New York Medical College. There is no registration fee. Contact: Sanford Sall, MD, Director, Gynecologic Malignancy Service, New York Medical College, 1249 Fifth Avenue, New York, New York 10029.

NOVEMBER 16-19, 1969
ASSOCIATION OF MILITARY SURGEONS OF THE UNITED STATES

Annual Meeting: Sheraton-Park Hotel, Washington, D.C. Keynote Speaker: Gerald D. Dorman, MD, President of the American Medical Association. For further information, contact: Brig. Gen. James A. Wier, MC, USA, General Chairman, Association of Military Surgeons of the United States, 1500 Massachusetts Ave., NW, Washington, D.C. 20005.

NOVEMBER 16-20, 1969
AMERICAN ASSOCIATION OF BLOOD BANKS

Annual Meeting: Shamrock Hilton Hotel, Houston, Texas. Principal Speaker: Denton A. Cooley, MD. The program will include papers on advances in the use of platelets, frozen blood, the discovery of new blood sub-types, use of adenine in blood preservation, and a symposium on antigen-antibody reactions. For further information, contact: Frank C. Coleman, MD, President, American Association of Blood Banks, Suite 1322, 30 North Michigan Avenue, Chicago, Illinois 60602.

NOVEMBER 17-21, 1969
WORLD FEDERATION FOR MENTAL HEALTH/(US) NATIONAL ASSOCIATION FOR MENTAL HEALTH

World Mental Health Assembly: Shoreham Hotel, Washington, D.C. The theme is "Mental Health in the Community." Between 500-700 guests from abroad are expected to be among the over-all registration of 2,000. For further information, contact: Paul Lemkau, MD, 615 N. Wolfe St., Baltimore, Md. 21205.

NOVEMBER 17-21, 1969
NEW YORK UNIVERSITY POSTGRADUATE MEDICAL SCHOOL

Postgraduate Course—Correlative Neuroradiology. Director: Irvin I. Kricheff, MD, Associate Professor of Radiology. For further information, contact: Office of the Recorder, New York University Postgraduate Medical School, 550 First Avenue, New York, New York 10016.

NOVEMBER 18, 1969
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Medical Management of Chronic Renal Disease: University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201. Speaker: Dr. Lewandowski. The conference will be held in the Psychiatric Institute, Room 1-704 at 4:00 PM.

NOVEMBER 19,1969
MARYLAND KIDNEY FOUNDATION

Seminar—Renal Transplantation: Present and Future: University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Maryland 21201. Speaker: G. Melville Williams, MD, Professor of Surgery, The Johns Hopkins University School of Medicine. The seminar will begin at 5:00 PM.

NOVEMBER 20, 1969
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Postgraduate Course—Hypertension & Renal Disease. Director: Glenn D. Lubash, MD. Designed for the practitioner of medicine, the course deals with the newer concepts and techniques in the treatment of hypertension and renal disease. For further information, contact: The Committee on Continuing Medical Education of the University of Maryland School of Medicine, 522 W. Lombard St., Baltimore, Maryland 21201.

NOVEMBER 20-22, 1969
TEXAS HEART ASSOCIATION/AMERICAN HEART ASSOCIATION

Special Scientific Session: Mexico City. For further information, contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Maryland 21201.

NOVEMBER 17-21, 1969
WORLD FEDERATION OF MENTAL HEALTH/NATIONAL ASSOCIATION FOR MENTAL HEALTH

World Mental Health Assembly: Shorcham Hotel, Washington, D.C. For further information, contact: Paul V. Lemkau, MD, Chairman, 615 North Wolfe St., Baltimore, Maryland 21205.

NOVEMBER 30, 1969
INTERNATIONAL COLLEGE OF SURGEONS/INTERNATIONAL SURGERY

Journalism award for the best scientific paper submitted by a surgical resident. A $500.00 cash award is being made available through a grant from Carroll J. Bellis, MD, a Fellow of the International College of Surgeons. For further information, write: Surgical Resident Award Program, International Surgery, 1516 N. Lake Shore Drive, Chicago, Ill. 60610.

NOVEMBER 30-DECEMBER 3, 1969
THE AMERICAN MEDICAL ASSOCIATION

Clinical Convention: Convention Center Complex, Denver, Colorado. The convention will include scientific sessions and the showing of 25 medical motion pictures. Write: The American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

DECEMBER 3, 1969
MARYLAND KIDNEY FOUNDATION

Seminar—Dialyzable Poisons: University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. Speaker: John F. Maher, MD, Professor of Medicine, Director, Division of Nephrology, University of Missouri School of Medicine. The seminar will begin at 5:00 PM.

UNITED FUND Now a Reality

The need for a consolidation of major fund drives in the Central Maryland area has long been apparent. The competition for top leadership among the various appeals put an undue burden on businessmen and their executive personnel. The public was bombarded with requests for donations, and even the housewife was met so often with an outstretched hand that many eventually refused to answer the urgent ringing of their doorbell.

In July, 1967, a resolution passed by the Chamber of Commerce stated that "the Directors of the Chamber of Commerce of Metropolitan Baltimore approve in principle the consolidation, at the earliest practical date, of all major charitable fund-raising drives into one annual campaign; and the Directors urge representatives of all Baltimore area fund appeals to work aggressively towards an early consolidation."

In October, 1967, representatives of the United Community Funds and Councils of America met with Frederick L. Wehr, of the Monumental Life Insurance Company, and Chairman of the Joint Fund Committee of the United Appeal, and the groundwork was laid.

The months that followed saw many meetings with representatives of the major fund drives, and with business and professional men from all fields. Early in the planning stages, representatives of labor were brought into the planning, and the concept of a United Fund was enthusiastically endorsed by all segments of the labor movement.

After uncounted man-hours and meetings involving the major fund-raising organizations and most of the top civic leaders from the fields of business and labor, a committee headed by Harry B. Cummings, recently retired Vice President and General Manager of the Metals Products Division of the Koppers Company, was organized to plan and implement steps necessary to the formation of a United Fund to be governed by the citizens of the Central Maryland Area.

The committee members Mr. Cummings and Herbert G. Bailey, Jr., Irving Blum, Harper R. Clark, Owen Daly, II, Alonzo G. Decker, Jr., Arthur G. Foster, Albert D. Hutzler, Jr., Henry J. Knott, John A. Luetkemeyer, Harry L. Lippincott, Nicholas F. Mueller, J. Stevenson Peck, Austin E. Penn, Nicholas V. Petrou are represented by Harry W. Smith, Sr., L. Mercer Smith, W. G. Smith, Walter Sondheim, Jr., Frederick L. Wehr. They realized it is not enough to try to rebuild a city with stone and cement, but that the health, happiness and well-being of the individual citizen is an even more important part of that rebuilding.

They realized, too, that those voluntary agencies supported by public donations are the most important weapon in the fight against pain and misery, for it is through these agencies that the sick and injured are given care and rehabilitation, the disturbed find peace, the troubled find help, that families, the basis of our society, are counseled and remain as firm, strong units, that children are cared for and given guidance onto the right paths, that the older citizens of our community find care and companionship.

The task was monumental. Funds had to be raised to continue to meet these needs, and still not overburden the public that had been called upon to support them.

After months of consultation and discussion, plans were drawn, a charter devised, and by-laws written that place in the hands of the public the management of its own fund-raising campaign.

Under the provisions of the United Fund, businesses and individuals will be called upon only one time each year to donate to those agencies that are considered necessary for the well-being of the entire community.

All charitable groups are invited to join this long-needed revision in fund-raising policies in the Central Maryland area to alleviate the unnecessary burden placed on the giving public by multiplicity of appeals and still maintain those services vitally necessary to the continued health and growth of the area.



Baltimore's Gourmet mail order seafood house offers shipments of fresh Chesapeake Bay Seafood . . .

anywhere in the country



. . . to the home, with customer satisfaction guaranteed. Shipments arrive in perfect condition or we reship at our expense or refund.

Chesapeake Farm Inc.
110 NORTH EUTAW STREET
BALTIMORE, MARYLAND 21201
685-8882 LOCATED AT LARKIN'S SEAFOOD

THIRD ANNUAL SEMINAR

ON THE MEDICAL ASPECTS OF SPORTS

Saturday, December 6, 1969 — 9:00 AM to 4:30 PM

Catonsville Community College,
800 South Rolling Road, Catonsville

9:00 AM Registration

10:00 AM Opening Remarks

10:15 AM Room A—**Reflection on the 1968 Olympics Conducted at High Altitude**
Thomas F. Waddell, MD
Georgetown University Hospital
Washington, D.C.

Room B—**Physical Medicine in Athletic Rehabilitation**
Alvin M. Brown, MD
Medical Director
Atlanta Southside Comprehensive Health Center
Atlanta, Georgia

11:30 AM Room A—**Conditioning of the Athlete**
Mr. James Kehoe
Director of Athletics
University of Maryland
College Park, Maryland

Room B—**Neurological Injuries—Field Diagnosis, and Transportation**
Charles W. Henderson, MD
Baltimore, Maryland

12:15 PM Lunch—May be purchased on the campus

1:30 PM Room A—**The Role of "Drugs" in Athletics**
William J. Kinnard, Jr., PhD
Dean and Professor of Pharmacology
University of Maryland
School of Pharmacy
Baltimore, Maryland

Room B—**Athletic Competition for Women and Teen-Age Girls**
(speaker to be announced)

2:45 PM Room A—**Psychosomatic Problems in the Athlete**
Burris Huesman, PhD
College of Physical Education
University of Maryland
College Park, Maryland

Room B—**Medicolegal Responsibility for the Athlete by School Administrator, Team Physician, and Coach**
Betty VanderSmissen, PhD
Penn State University
State College, Pennsylvania

3:30 PM Taping Clinics—Conducted on an informal basis so instruction can be more individualized

4:30 PM Adjournment

Program is sponsored by the Medical and Chirurgical Faculty of the State of Maryland and the Division of Health, Physical Education, and Recreation of Catonsville Community College.

3rd Annual Seminar on the Medical Aspects of Sports, December 6, 1969

Detach and return this reservation form to:

Medical and Chirurgical Faculty
1211 Cathedral Street
Baltimore, Maryland 21201

Name .....

Address .....

Enclosed is my check for $.....

($4 per person; students $1. Does not include lunch.)

Make Checks payable to:

Medical and Chirurgical Faculty

Please indicate your preference:

10:15 AM
Reflection on 1968 Olympics _____
Physical Medicine _____

11:30 AM
Conditioning _____
Neurological Injuries _____

1:30 PM
Role of "Drugs" _____
Athletic Competition for Women _____

2:45 PM
Psychosomatic Problems _____
Medicolegal Responsibility _____

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.

Miss Gladys Deeds
Manager

213 West Saratoga St. 727-7011

A COMPLETE ORTHOPEDIC and CORRECTIVE DEPARTMENT

To Fill Your Doctor's Prescription

The following types are carried in stock:



- Thomas Heel Oxfords and High Tops
- Straight Last
- Pronators
- Supinators
- Pre-Walking Reverse and Straight Last
- Dennis Brown Splints Rented

BRIDGEFORTH'S JUNIOR BOOTERY

Edwards

4426 Park Heights Ave.
Baltimore, Maryland 21215
664-4914

DO YOU NEED



If you are a doctor or dentist or supervise a staff in a hospital or nursing home, there are times when you have wished that help was a phone call away. Now it is. Call us night or day for the nursing or medical office employees you need. Our service is national, our employees are experienced, screened, insured and bonded.

MEDICAL PERSONNEL POOL
Washington—Phone 667-6345
Baltimore—Phone 685-5053

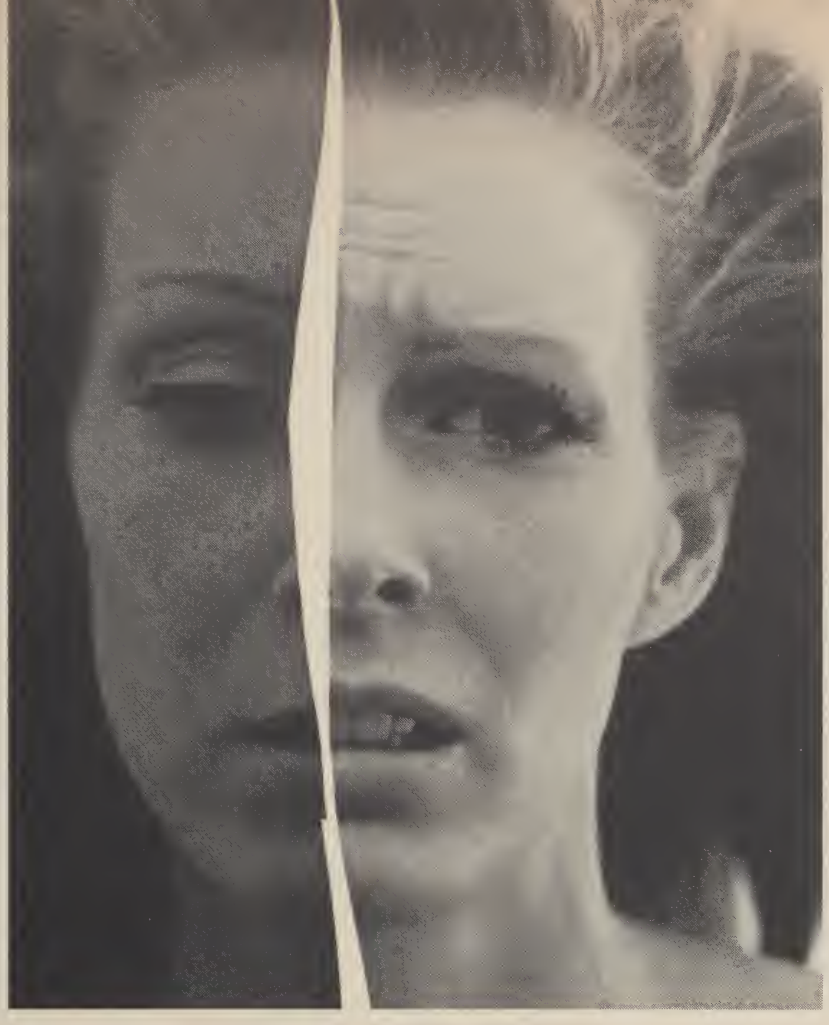
For your next meeting, banquet or convention . . . consider



THE NEW OCEAN CITY
CONVENTION HALL

One of the most beautiful facilities on the east coast—ideal for sales meetings, private parties, banquets, conventions, trade shows . . . concerts, dances and sporting events. Will accommodate up to 2000 at a banquet, 3000 at a convention; meeting rooms for 50 to 300 persons. Air-conditioned and heated—for year-round use. Large private parking area.

For complete information . . . . write
EARL G. BAIRD, *Executive Director*
4000 Philadelphia Ave., Ocean City, Md. 21842



symptoms of mixed anxiety-depression are rarely clear-cut...
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69-384

Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic /antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other CN depressants. As with all CNS-acting drugs, ca tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, operati machinery, driving). Though physical and ps chological dependence have rarely been report on recommended doses, use caution in a ministering Librium (chlordiazepoxide hydr chloride) to known addiction-prone individu or those who might increase dosage; withdraw symptoms (including convulsions), followi discontinuation of the drug and similar to tho seen with barbiturates, have been reported. U of any drug in pregnancy, lactation, or in wom of childbearing age requires that its potenti benefits be weighed against its possible hazar As with all anticholinergic drugs, an inhibiti effect on lactation may occur.

PRECAUTIONS: In elderly and debilitate limit dosage to smallest effective amount to pr clude development of ataxia, oversedation confusion (not more than two capsules per d initially; increase gradually as needed and tole

or here.



ed). Though generally not recommended, if mbination therapy with other psychotropics ems indicated, carefully consider individual harmacologic effects, particularly in use of po- ntiating drugs such as MAO inhibitors and henothiazines. Observe usual precautions in resence of impaired renal or hepatic function. aradoxical reactions (*e.g.*, excitement, stimula- n and acute rage) have been reported in psy- iatric patients. Employ usual precautions in eatment of anxiety states with evidence of im- nding depression; suicidal tendencies may be esent and protective measures necessary. Vari- le effects on blood coagulation have been ported very rarely in patients receiving the ug and oral anticoagulants; causal relation- ip has not been established clinically.

ADVERSE REACTIONS: No side effects or anifestations not seen with either compound ne have been reported with Librax. When lordiazepoxide hydrochloride is used alone, owsiness, ataxia and confusion may occur, pecially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

heavenly relief
for unearthly cough

Benylin®
EXPECTORANT



Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

Meeting Minutes

Ten members of the Board of Directors of the Baltimore City Medical Society met on September 2, 1969 at 4:30 PM at 1211 Cathedral Street, Baltimore, Maryland. The meeting was called to order by the President, Raymond C. V. Robinson, MD.

The minutes of the June 3rd meeting of the Board were approved.

The first item on the agenda was related to the forthcoming meeting of the House of Delegates of the Medical and Chirurgical Faculty. After a brief discussion of the items on the agenda, the Board met with the delegates and their alternates, as is the policy of the Baltimore City Medical Society.

The next item on the agenda was the report of the Finance Committee submitted by Emmanuel A. Schimunek, MD, D. Frank Kaltreider, MD, and Philip F. Wagley, MD. The present assets of the Society are as follows:

Savings Bank of Baltimore	$15,000.00
American Telephone & Telegraph (Bonds)	1,872.94
National Cash Register Company (Bonds)	2,017.51
International Harvester Co. (Bonds)	2,078.16
General Motors Acceptance (Bonds)	1,955.44
Consolidated Edison (Bonds)	2,020.44
Massachusetts Investors Growth Stock Fund	16,990.12
T. Rowe Price Growth Stock Fund	20,243.50
Mercantile-Safe Deposit & Trust (Checking Acct)	16,704.06
Total	$78,882.17

The estimated expenses of the Society per year are $33,000: $26,000 is paid to the Medical and Chirurgical Faculty for Rent and Services and the additional $7,000 is used for general office expenses.

The following recommendations made by the Finance Committee were approved by the Board:

1. A Finance Committee consisting of three members and the treasurer as an ex-officio member should be appointed each year. This Committee should meet the first week in January to decide what should be done with any excess fund of the Society. To ensure continuity only one member of the Committee should be replaced each year and should be appointed from the current membership of the Board.
2. All bonds presently held by the Society should be sold and the funds realized from such sale should be invested in T. Rowe Price Growth Stock Fund, Inc.
3. The present savings account of $15,000 should be converted to a 5% account.
4. Additional savings accounts should be opened by the Society in which all dues and interest should be placed. The balance in the Society's checking account should be kept at $7,000 and all other cash should be placed in the savings accounts. A total of $33,000 should be kept in savings accounts and the checking account at the end of each year to cover the Society's op-

erating expenses. Whenever a savings account reaches $15,000, the treasurer should be notified so that an additional account can be opened.

5. All interest and capital gains in T. Rowe Price Growth Stock Fund, Inc. should be reinvested in this fund.
6. All interest and capital gains on Massachusetts Investors Growth Stock Fund should be reinvested in this fund.
7. At the end of each year an audit of the Rent and Services payments to Med-Chi should be requested.

A suggestion was made that the Finance Committee investigate the possibility of placing some of the funds in three-month Government bonds with one of the Banks as this would yield approximately 7% interest.

Drs. Schimunek, Kaltreider, and Wagley were asked to continue as members of the Finance Committee and each agreed.

Robert B. Goldstein, MD, Secretary of the Society, reported that he planned to discuss the binding and preservation of the minutes of the Society with an expert in the field in the near future and would report his findings at the next meeting of the Board.

The next item on the agenda was a letter from the Baltimore City Health Department requesting the Society to assist in preparing a standard physical examination form for children entering camps and other recreational facilities. Dr. Robinson requested W. Kenneth Mansfield, MD, Paul A. Mullan, MD, Hammond J. Dugan, MD, and Frederick K. Adams, MD to study this problem with Jimmie L. Rhyne, MD, Director of Child Health Services, Baltimore City Health Department, and submit their recommendations to the Board for consideration.

A letter was read to the Board of Directors from a physician presently in service of the U.S. Public Health Service requesting the permission of the Society to accept employment in a local hospital and engage in some private practice. It was the opinion of the Board that if the physician met the requirements of the Board of Medical Examiners of the State of Maryland, the Society should have no objection to these activities.

Correspondence was read from George M. Owen, MD, Associate Professor of Pediatrics, Ohio State University, who is presently engaged in a national research project evaluating the nutritional status of preschool children. Dr. Owen requested the sanction of the Baltimore City Medical Society for that portion of the study which would be conducted in Baltimore City. After much discussion, it was decided that the Baltimore City Medical Society would support the study if the requirements with regard to physician licensure set down by the Board of Medical Examiners were complied with by the physicians involved. The program has already been accepted by the City, County and State Health Departments.

The salaries of the office staff of the Baltimore City Medical Society were reviewed and appropriate adjustments made.

The meeting was adjourned at 5:45 PM.

Baltimore County Medical Association

The Baltimore County Medical Asosciation met at Mount Wilson Hospital, on September 17, at the invitation of William Newcomer, MD, and the hospital staff.

After lunch, the President, Theodore Patterson, MD, conducted the routine business of the association. Ten new members were admitted to active membership.

A scientific session followed. Elmer P. Sauer, MD, of the Mt. Wilson Hospital staff, spoke first on the subject of emphysema, and later on the present treatment of tuberculosis.

At the end of the session, Dr. Patterson thanked Dr. Sauer and the staff for the luncheon and the very interesting scientific program. The meeting was well attended.

B. B. VELEZ, MD, *Chairman*
Public Relations



Insurance For The Doctor

PROFESSIONAL LIABILITY*

Workmen's Compensation
Equipment Floater
Bonds on Employees
Public Liability
Fire Insurance
Disability Income
Term Life Insurance
Pension Plans

* *Endorsed by MEDICAL SOCIETY OF D. C. & MD.*

Russell, Marsh & Kennedy, Inc.

5151 WISCONSIN AVE. WASHINGTON, D. C. 20016 244-7600

Drugs Prescribed in Obstetrics

Drugs used in obstetrics present a unique problem. They not only have an effect on the mother, but they may have an effect on the developing conceptus. It is established that certain chemical compounds that are administered to pregnant women can influence adversely the development of the unborn child. However, it is difficult to prove in human beings a causal relationship between administration of a drug to the mother and the appearance of a congenital malformation in her child. Although all therapeutic agents are not capable of transmission across the placental membranes, some drugs do affect the fetus in one way or another.

Desirable are therapeutic drugs that do not pass into the fetal circulation. These drugs benefit the maternal organism without causing toxic levels in the fetus. In this category may be such agents as barbiturates which normally are detoxified by the liver. Nevertheless, the mere inability of a drug to be transported across the placental barrier does not assure complete protection for the unborn child. For the most part, scientists are not sure what mechanisms cause teratogenic results. To the list of hazardous antibiotics and sulfas we must add insulin, thyroid hormone, cortisone, vitamin A, quinine, most anticancer drugs, and even toxic doses of aspirin. In almost every instance, however, the defect produced depends upon three factors: the size of dosage, its frequency, and the stage of pregnancy when the drug is administered.

Since the thalidomide tragedy in 1960-62 and the appearance of phocomelia resulting from the administration of that drug to pregnant women, much effort has been directed toward research and the acquisition of knowledge concerning the dangers involved in prescribing drugs to pregnant women. Dr. Lowell T. Coggeshall was made chairman of a 14-member Commission on Drug Safety established in 1962; later, with the encouragement of The Department of Health, Education, and Welfare, the National Academy of Science-National Research Council established the Drug Research Board, the permanent advisory body on drug safety.

Medicine is a living, changing discipline. To keep informed the practicing physician reads current scientific literature. Of current interest to obstetricians are tables on information on drugs, titled "Drugs Adversely Affecting the Human Fetus," published in *Hospital Formulary Management,* June, 1969. This information is summarized in an effort to alert physicians to the increasing number of drugs that are potentially dangerous to the developing fetus. The tables are compiled by Al Takata, Pharm. D., of Alta Bates Community Hospital, Berkeley, California. Reprints are available from Clissold Publishing Company, 105 West Adams Street, Chicago, Illinois 60603.

M. Edward Davis, MD

(From the ACOG Newsletter, Sept. 1969)

IN THE BUILDING AND TRADITION OF THE BALTIMORE EYE EAR AND THROAT HOSPITAL



AT THE FRANCIS SCOTT KEY MONUMENT
Near Jones Falls Expressway and State Office Building

Key Circle Hospice
NURSING HOME & EXTENDED CARE FACILITY
R. W. Hansen, *Administrator*
1214 EUTAW PLACE BALTIMORE, MARYLAND 21217
523-7800
THE BEST CARE AVAILABLE
UNDER CONSTANT MEDICAL SUPERVISION
MODERATE RATES

Coming out of a depression.

And it can often begin to happen in 3 to 5 days with an antidepressant like Pertofrane. There's a lifting of depressed mood... a restoration of psychomotor activity. Patients usually begin to cope, work, maybe play, even enjoy.

It's not all beautiful. Sometimes there are side effects. And not everybody can take the drug. It may even be a slow process. But along with the care and comfort you give depressed patients, consider Pertofrane. Then consider the response.

Please read the prescribing information for full details on contraindications, warnings, precautions, adverse reactions and dosage. It's summarized on the left.

Pertofrane®

desipramine hydrochloride

New 50-mg. capsules now available

Pertofrane® desipramine hydrochloride

Indication: Mental depression.

Contraindications: Do not use MAO inhibitors concomitantly or within 2 weeks of the use of this drug. Hyperpyretic crises or severe convulsive seizures may occur with such combinations; potentiation of adverse reactions can be serious or even fatal.

When substituting Pertofrane in patients receiving an MAO inhibitor, allow an interval of at least 14 days. Initial dosage in such patients should be low and increases should be gradual and cautiously prescribed.

The drug is contraindicated following recent myocardial infarction and in patients with a known hypersensitivity to tricyclic antidepressants.

Warning: Activation of psychosis may occasionally be observed in schizophrenic patients. Due to atropine-like effects and sympathomimetic potentiation, use only with the greatest care in patients with narrow-angle glaucoma or urethral or ureteral spasm.

Do not use in patients with the following conditions unless the need outweighs the risk: severe coronary heart disease with EKG abnormalities, progressive heart failure, angina pectoris, paroxysmal tachycardia and active seizure disorder (may lower seizure threshold).

Desipramine and the parent compound, imipramine, have been shown to block the action of guanethidine and related adrenergic neuron-blocking agents.

Hypertensive episodes have been observed during surgery.

The concurrent use of other central nervous system drugs or alcohol may potentiate adverse effects. Since many such drugs may be used during surgery, desipramine should be discontinued prior to elective procedures.

Caution patients on the possibility of impaired ability to operate a motor vehicle or dangerous machinery.

Do not use in women who are or may become pregnant unless the clinical situation warrants the potential risk, and do not use in patients under 12 years of age.

Because of increased sensitivity to the drug, use lower than normal dosage in adolescent and geriatric patients.

Precautions: Potentially suicidal patients require careful supervision and protective measures during therapy. Discontinuation of the drug may be necessary in the presence of increased agitation and anxiety shifting to hypomanic or manic excitement.

Atropine-like effects may be more pronounced (e.g. paralytic ileus) in susceptible patients and in those receiving anticholinergic drugs (including antiparkinsonism agents).

Prescribe cautiously in hyperthyroid patients and in those receiving thyroid medications; transient cardiac arrhythmias have occurred in rare instances.

Periodic blood and liver studies should supplement careful clinical observations in all patients undergoing extended courses of therapy.

Adverse Reactions: The following have been reported: *Nervous System:* dizziness, drowsiness, insomnia, headache, disturbed visual accommodation, tremor, unsteadiness, tinnitus, paresthesias, changes in EEG patterns, epileptiform seizures, mild extrapyramidal activity, falling and neuromuscular incoordination. A confusional state (with such symptoms as hallucinations and disorientation), particularly in older patients and at higher dosage, may require discontinuation of the drug. *Gastrointestinal Tract:* anorexia, dryness of the mouth, nausea, epigastric distress, constipation and diarrhea. *Skin:* skin rashes (including photosensitization), perspiration and flushing sensations. *Liver:* rare cases of transient jaundice (apparently of an obstructive nature) and liver damage. If jaundice or abnormalities in liver function tests occur, discontinue the drug and investigate. *Blood Elements:* bone-marrow depression, agranulocytosis, thrombocytopenia and purpura. If these occur, discontinue the drug. Transient eosinophilia has been observed. *Cardiovascular System:* orthostatic hypotension and tachycardia. Carefully supervise patients requiring concomitant vasodilating therapy, particularly during initial phases. *Genitourinary System:* urinary frequency or retention and impotence. *Endocrine System:* occasional hormonal effects, including gynecomastia, galactorrhea and breast enlargement, and decreased libido and estrogenic effect. *Sensitivity:* urticaria and rare instances of drug fever and cross-sensitivity with imipramine.

Dosage: All patients except geriatric and adolescent: 50 mg. t.i.d. (150 mg. daily). Dosage may be increased up to 200 mg. daily. Geriatric and adolescent patients should usually be started with lower dosage (25 to 50 mg. daily) and may not tolerate higher doses. Dosage may be increased up to 100 mg. daily.

Lower maintenance dosages should be continued for at least 2 months after obtaining a satisfactory response.

Mild anxiety and agitation which may accompany depression usually remit as the depression responds. Occasionally, however, a sedative or tranquilizer may be indicated.

Availability: Maroon and pink capsules of 50 mg. in bottles of 100; pink capsules of 25 mg. in bottles of 100 and 1000. (B)46-530-G

For complete details, please see the full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

Geigy

It's beautiful!





Ornade® Spansule®

brand of
sustained release capsules

Trademark

Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

SK&F **Smith Kline & French Laboratories**



A Service of the Tuberculosis Association of Maryland

tuberculosis

Home Care of Chronic Respiratory Disease

In an effort to reduce the number of hospital readmissions, or prevent permanent hospitalization of patients with chronic respiratory insufficiency, a Home Care Program was established ten years ago by the Winnipeg General Hospital. Paramedical personnel play an important role in the successful operation of the program at low cost.

In 1958, the Winnipeg General Hospital (Manitoba, Canada) established a "Home Care Program" for patients with chronic respiratory insufficiency. It was hoped that repeated hospital admissions or permanent hospitalization for such patients would prove unnecessary. This report is concerned with the experience during the first ten years.

Patients with repeated hospital admissions over a period of years, or with persistent hypoxia and hypercapnia, despite intensive therapy, were given high priority for admission to the program. The suitability of the patient was judged by his medical history and physical status, respiratory function, home and family situation, and medical and paramedical requirements.

During the ten-year period the 148 admissions spent a total of 71,247 days on the program. The average was 482 days. There were 70 deaths (47%). The average length of time on the program of those who died was 361 days.

Of 14 patients admitted to the program between 1958 and 1962, only one is alive at the time of this report. Of 39 admitted between 1963 and 1965, 15 (48%) are still alive.

Rehospitalization was required for 82 patients, or 55%. However, the total hospitalization of these patients was 4,078 days, and they were on the Home Care Program only 5.7% of this time.

Reuben M. Cherniack, MD; Robert G. Handford, MD, and Edith Svanhill. *The Journal of the American Medical Association,* May 5, 1969.

Cost of Program

The cost of the program for one year (1967) was $15.262.69. The cost per patient per year was $193.20, or 53 cents a day. The costs include maintenance of equipment and administration as well as physician and nurses fees, homemaking service, transport, meal delivery, and oxygen. In Winnipeg this annual cost would cover only four or five days in an acute-care hospital bed; seven to eight days in a chronic-care hospital, and ten to twelve days in a nursing home.

Financing of the program is from funds of the Manitoba Hospital Commission and from a provincial government rehabilitation health grant. A few patients may be asked to contribute to the cost on the basis of their reported taxable income, but this is rare. Intermittent Positive Pressure Breathing (IPPB) equipment is loaned to the individual patient from a central pool operated by the provincial government.

Patients thus far admitted to the study were all suffering from a chronic illness, principally respiratory, cardiac, neurological, or malignant disease.

The program is administered by a medical director, or secretary, and a nursing coordinator who serve as a "health team" in providing the medical and paramedical services required by the patient. The team has responsibility also for the dissemination of reports to and from other agencies active in the program.

In 1967 nurses of the Victorian Order of Nurses made 1,560 visits to the patients at home. Reassess-

ment of the patient's condition was made at intervals of from two to six months in the outpatient clinic of the hospital. When necessary, the resident physician assigned to respiratory diseases visited the patient at home.

Other Services

Provision is also made for the services of such other paramedical personnel as inhalation therapists and physiotherapists and, where called for, a homemaker to assist the family. Although the majority of patients go to the hospital for physiotherapy, a physiotherapist, on occasion, may visit the home. Regular communication is maintained with patients who live in the country some distance from the hospital.

In the care of chronic respiratory disease patients, the measures used have been designed primarily to mitigate functional disturbances and to prevent exacerbations of acute respiratory insufficiency. The majority of these patients had chronic obstructive pulmonary disease. Among them resistance to airflow was a major problem, probably due to secretions, loss of elasticity, or bronchospasm or both. Care of these patients has been directed at reducing the work of breathing, increasing alveolar ventilation, and improving exercise tolerance.

Reduction in secretions was accomplished by removal of irritants, particularly cessation of smoking; by saline douches of the nasal passages in patients with postnasal discharge; and by prompt and vigorous treatment of infection.

By adequate hydration and postural drainage, elimination of secretions was improved. Bronchospasm was relieved by effective oral and aerosol administration of bronchodilators. For many patients with chronic obstructive lung disease who were unable to take a deep breath and had inadequate alveolar ventilation persistently, IPPB was provided at home.

Increased Mobility

Diaphragmatic breathing training was a part of the program, as was gradual increase in physical activity. Although excessive physical activity was avoided during an acute illness, invalidism was discouraged. General physical fitness improved with reasonable physical activity through gradually increased exercise. This ability to increase mobility and exercise tolerance improved mental outlook.

Although it is disappointing that the life span of the patients on the program was not longer, it must be emphasized that the prerequisites for admission were stringent. The real benefits cannot be deduced from the number of hospital readmissions and the mortality statistics. Several patients with severe insufficiency were sent home even though it was realized they might have to be readmitted to the hospital. In several instances, patients were discharged from the hospital to spend their last few days at home.

Care of the patients was primarily centered around paramedical services rather than medical. The cost of home visits by residents was only a small part of the total cost of the program. Paramedical personnel should certainly be considered an integral and essential component of the management of patients with chronic respiratory insufficiency.

The program made prolonged stays in the hospital unnecessary, and likewise long confinement in nursing homes or extended care institutions. The patient and his family responded to the opportunity for him to remain in comfortable and familiar surroundings during the late phases of his illness.

MANUEL SCHWARTZ
HEARING REHABILITATION
321 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201
DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION
Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

TOWSON TELEPHONE SECRETARIES
Mrs. Isabel Flanagan—Owner
WE ANSWER YOUR PHONE
24 HOURS A DAY — EVERY DAY
MONTH - TO - MONTH BASIS
ORDER BY PHONE
"INSURE YOURSELF AGAINST LOSS OF PATIENTS' CALLS"
7112 York Rd. 825-1300
Just below
Stevenson Lane TOWSON, MD.

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City
health department

New Deputy Commissioner

John B. De Hoff, MD, former director of local health services in the Baltimore City Health Department, has been named Deputy Commissioner, effective July 31. In this post Dr. De Hoff will help chart the course of public health in Baltimore by assisting in the formation and direction of the city-wide public health program. As Deputy Commissioner, Dr. De Hoff will work closely with the city's medical profession and health-oriented groups in their efforts to bring better health to all Baltimoreans.

A life-long resident of Baltimore, Dr. De Hoff is the son of the late George W. De Hoff, MD. He received his education in the public schools of the city and at The Johns Hopkins University where he received the BA, MD, and Master of Public Health degrees. During World War II, he served in the Army Medical Corps both in the United States and Europe. Entering private practice in the city after the war, Dr. De Hoff maintained his army reserve status and retired as Colonel and Commander of the 92nd Field Hospital in 1965. That same year he became Assistant Commissioner and director of local health services in the city's Health Department.

Dedicated to improving community medicine, Dr. De Hoff has taken an active interest in the Medical and Chirurgical Faculty of Maryland and the Baltimore City Medical Society. He has served on committees concerned with medical care, diabetes detection, sports medicine, and others in the preventive medicine field.

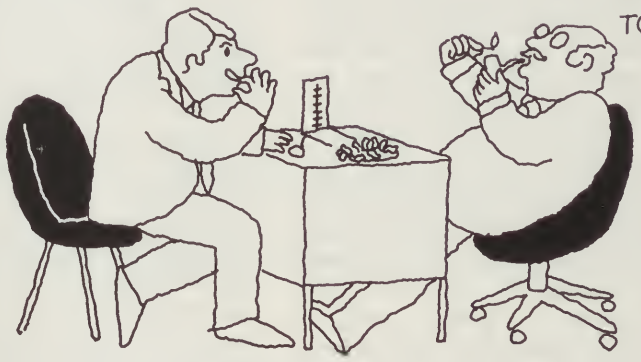
As director of local health services, Dr. De Hoff helped establish the Provident Hospital Comprehensive Neighborhood Health Center and serves as Vice President of the Neighborhood Council for the center. He is a member of the Community Health Council of Bon Secours Hospital, the Social Work Manpower Committee, the Advisory Council to the Job Skill Center, and others. In addition, he is also chairman of the organization committee for the Allied Health Sciences Consortium, a new local group for expanding educational opportunities in health fields for the disadvantaged.

Dr. De Hoff is an Associate in Medicine and Preventive Medicine at the University of Maryland and a lecturer in public health administration at The Johns Hopkins School of Hygiene and Public Health. Since he helped plan the Provident Hospital Comprehensive Neighborhood Health Center, he was also recently invited to offer testimony on comprehensive medical care programs for the poor before the United States Senate Subcommittee on Health.

Dr. De Hoff is a Fellow of the American Public Health Association and serves as representative for the local affiliate, the Maryland Public Health Association. He is also a member of the Aerospace Medical Association and the Society of Medical Consultants to the Armed Forces. His past achievements have earned him the Alexander Cochran Bowen-Harlow Brooks Scholar Award of the New York Academy of Medicine, and Certificates of Achievement from the U.S. Army. He has written numerous articles on a wide variety of medical subjects which have been published in local and national professional journals.

The Apprehensive Hypertensive

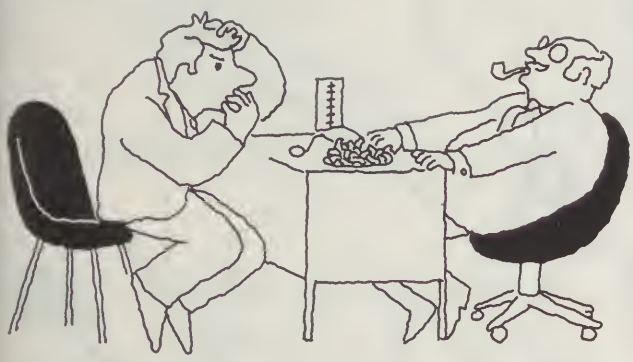




Regroton® to lower blood pressure

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increas respiratory secretions, nasal congestion, cyanosis and anorexia m occur in infants born to reserpine-treated mothers. *Precautions:* Antih pertensive therapy with this drug should always be initiated cautious in postsympathectomy patients and in patients receiving ganglion blocking agents, other potent antihypertensive drugs, or curare. Redu dosage of concomitant antihypertensive agents by at least one-half. avoid hypotension during surgery, discontinue therapy with this age two weeks prior to elective surgical procedures. In emergency surge use, if needed, anticholinergic or adrenergic drugs or other supporti measures as indicated. Because of the possibility of progression renal damage, periodic kidney function tests are indicated. Discontin if the BUN rises or liver dysfunction is aggravated. Hepatic coma m be precipitated. Electrolyte imbalance, sodium and/or potassium d pletion may occur. If potassium depletion should occur during therap the drug should be discontinued and potassium supplements give provided the patient does not have marked oliguria. Take particular ca in cirrhosis or severe ischemic heart disease and in patients receivi





and allay anxiety in hypertension

corticosteroids, ACTH, or digitalis. Severe salt restriction is not recommended. Use cautiously in patients with ulcerative colitis or gallstones (biliary colic may be precipitated). Bronchial asthma may occur in susceptible patients. *Adverse Reactions:* The drug is generally well tolerated. The most frequent side effects are nausea, gastric irritation, vomiting, diarrhea, constipation, muscle cramps, headache, dizziness and acute gout. Other potential side effects include angina pectoris, anxiety, depression, bradycardia and ectopic cardiac rhythms (especially when used with digitalis), drowsiness, dull sensorium, hyperglycemia and glycosuria, hyperuricemia, lassitude, restlessness, transient myopia, impotence or dysuria, orthostatic hypotension which may be potentiated when chlorthalidone is combined with alcohol, barbiturates or narcotics, leukopenia, aplastic anemia, skin rashes, thrombocytopenia, agranulocytosis, nasal stuffiness, increased gastric secretions, nightmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic atrophy and glaucoma, and pruritus. Eruptions and/or flushing of the skin, a reversible paralysis agitans-like syndrome, blurred vision, conjunctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B) 46-600-C

For details, please see complete prescribing information.

Regroton®
chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742


BALTIMORE
TOWSON
RUXTON
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
FOREST PARK
WALBROOK
ARLINGTON
PIMLICO
NORTH AVENUE
EDMONDSON AVENUE
FREDERICK AVENUE
PRATT STREET
WEST BALTIMORE
HIGHLANDTOWN
CANTON
ROSEDALE
FULLERTON
OVERLEA
HAMILTON
MERRITT PARK
DUNDALK
BROOKLYN
CURTIS BAY
WESTPORT
ARBUTUS
HALETHORPE
RELAY
ELKRIDGE
LINTHICUM
FERNDALE
GLEN BURNIE
PATAPSCO RIVER
NORTHWEST BRANCH
MIDDLE BRANCH
ANNE ARUNDEL COUNTY
BALTIMORE COUNTY
BELTWAY
FRIENDSHIP INTERNATIONAL AIRPORT
BALTIMORE NATIONAL PIKE
OLD FREDERICK RD
LIBERTY ROAD
REISTERSTOWN ROAD
HARBOR TUNNEL THRUWAY
BALTIMORE - WASHINGTON BLVD
CHARLES STREET
YORK ROAD
JOPPA ROAD
CROMWELL BRIDGE
HARFORD RD.
BELAIR RD.
COUNTY BELTWAY
RAVEN BOULEVARD
JONES FALLS EXPRESSWAY
FRANKFORD AVENUE
PHILADELPHIA
PULASKI HI
THRUWAY
HILLEN ST
GREENMOUNT
CLIFTON PARK AVENUE
HARBOR TUNNEL
EASTERN AVENUE
BOSTON ST
HOLABIRD AVENUE
MERRITT BOULEVARD
DUNDALK AVENUE
PENNINGTON AVE
PATAPSCO AVE
CHERRY HILL LANE
RITCHIE HIGHWAY
GOVERNOR
LIGHT ST
FORT AVE
RUSSELL STREET
WASHINGTON BLVD
HANOVER STREET
McCOMAS ST
POTEE ST
PATAPSCO AVENUE
HAMMONDS FERRY RD
ANNAPOLIS ROAD
OLD BELLE GROVE ROAD
NURSERY RD.
FORT MEADE
SOUTH-WESTERN
GWYNNS FALLS PK/W
GWYNNS FALLS PARK
LEAKIN PARK
HANLON PARK
DRUID HILL PARK
CLIFTON PARK
PATTERSON PARK
LOUDEN PARK CEM.
DRUID RIDGE CEM.
LAKE ROLAND PARK
BONNIE VIEW GOLF CLUB
CLIFTON GOLF COURSE
COUNTRY CLUB OF MARYLAND
ROLLING ROAD COUNTRY CLUB
PINE CREST SAN.
DEPT. OF MOTOR VEHICLES
BALTIMORE CITY HOSP
EASTERN AVENUE
PUBLICO RACE TRACK
SINAI HOSP.
CHILDRENS HOSP.
MONTEBELLO STATE HOSP.
BALTIMORE MEMORIAL STADIUM
JOHNS HOPKINS UNIVERSITY
JOHNS HOPKINS HOSPITAL
UNIVERSITY OF BALTO.
SHEPPARD PRATT HOSP.
STATE TEACHERS COL.
BOUCHER COLLEGE
MOUNT PLEASANT PARK
LOCH RAVEN PARKWAY (PROPOSED)
NORTHERN PARKWAY
HAZELWOOD AVE
WALTHER AVENUE
HILLEN ROAD
33RD ST
28TH ST
PRESTON STREET
BIDDLE ST.
MADISON STREET
MONUMENT STREET
FAYETTE ST
LOMBARD STREET
MULBERRY STREET
FRANKLIN STREET
McCULLOH STREET
DRUID HILL AVENUE
MONROE STREET
FULTON AVENUE
CAREY ST
HOWARD ST
CHARLES STREET
ST PAUL STREET
GREENMOUNT AVE
BROADWAY
PATTERSON PARK AVENUE
CONKLING STREET
JONES FALLS EXPRESSWAY
LAKE ROLAND
BELVEDERE AVENUE
COLD SPRING LANE
UNIVERSITY PARKWAY
ROLAND AVENUE
CHARLES STREET AVENUE
YORK ROAD
LOCH RAVEN BOULEVARD
PERRING PARKWAY
HILTON ST
CATON AVENUE
WILKENS AVE
EDMONDSON AVENUE
OLD COURT ROAD
PARK HEIGHTS AVENUE
NORTHERN PARKWAY
LIBERTY ROAD
WESTERN SOUTH
SOUTH-WESTERN
BALTIMORE NATIONAL PIKE
BALTIMORE - WASHINGTON BLVD
HARBOR TUNNEL THRUWAY
FRANKFORD AVENUE TUNNEL
CHARLES STREET AVENUE
YORK ROAD
JOPPA ROAD
CROMWELL BRIDGE
HARFORD RD.
BELAIR RD.
COUNTY BELTWAY
RAVEN BOULEVARD
JONES FALLS EXPRESSWAY
FRANKFORD AVENUE
PHILADELPHIA
PULASKI HI
THRUWAY
HILLEN ST
GREENMOUNT
CLIFTON PARK AVENUE
HARBOR TUNNEL
EASTERN AVENUE
BOSTON ST
HOLABIRD AVENUE
MERRITT BOULEVARD
DUNDALK AVENUE
PENNINGTON AVE
PATAPSCO AVE
CHERRY HILL LANE
RITCHIE HIGHWAY
GOVERNOR
LIGHT ST
FORT AVE
RUSSELL STREET
WASHINGTON BLVD
HANOVER STREET
McCOMAS ST
POTEE ST
PATAPSCO AVENUE
HAMMONDS FERRY RD
ANNAPOLIS ROAD
OLD BELLE GROVE ROAD
NURSERY RD.
FORT MEADE
SOUTH-WESTERN
GWYNNS FALLS PK/W
GWYNNS FALLS PARK
LEAKIN PARK
HANLON PARK
DRUID HILL PARK
CLIFTON PARK
PATTERSON PARK
LOUDEN PARK CEM.
DRUID RIDGE CEM.
LAKE ROLAND PARK
BONNIE VIEW GOLF CLUB
CLIFTON GOLF COURSE
COUNTRY CLUB OF MARYLAND
ROLLING ROAD COUNTRY CLUB
PINE CREST SAN.
DEPT. OF MOTOR VEHICLES
BALTIMORE CITY HOSP
EASTERN AVENUE
PUBLICO RACE TRACK
SINAI HOSP.
CHILDRENS HOSP.
MONTEBELLO STATE HOSP.
BALTIMORE MEMORIAL STADIUM
JOHNS HOPKINS UNIVERSITY
JOHNS HOPKINS HOSPITAL
UNIVERSITY OF BALTO.
SHEPPARD PRATT HOSP.
STATE TEACHERS COL.
BOUCHER COLLEGE
MOUNT PLEASANT PARK
LOCH RAVEN PARKWAY (PROPOSED)
NORTHERN PARKWAY
HAZELWOOD AVE
WALTHER AVENUE
HILLEN ROAD
33RD ST
28TH ST
PRESTON STREET
BIDDLE ST.
MADISON STREET
MONUMENT STREET
FAYETTE ST
LOMBARD STREET
MULBERRY STREET
FRANKLIN STREET
McCULLOH STREET
DRUID HILL AVENUE
MONROE STREET
FULTON AVENUE
CAREY ST
HOWARD ST
CHARLES STREET
ST PAUL STREET
GREENMOUNT AVE
BROADWAY
PATTERSON PARK AVENUE
CONKLING STREET
JONES FALLS EXPRESSWAY
LAKE ROLAND
BELVEDERE AVENUE
COLD SPRING LANE
UNIVERSITY PARKWAY
ROLAND AVENUE
CHARLES STREET AVENUE
YORK ROAD
LOCH RAVEN BOULEVARD
PERRING PARKWAY
HILTON ST
CATON AVENUE
WILKENS AVE
EDMONDSON AVENUE
OLD COURT ROAD
PARK HEIGHTS AVENUE
NORTHERN PARKWAY
LIBERTY ROAD
WESTERN SOUTH
SOUTH-WESTERN
BALTIMORE NATIONAL PIKE
BALTIMORE - WASHINGTON BLVD
HARBOR TUNNEL THRUWAY
FRANKFORD AVENUE TUNNEL

Restaurants of Distinction

Locations indicated by numbers on map

6

MILTON INN

Circa 1740

Dine Amid Early American Charm
Warm, Gracious and Inviting

Selected By Life & Time Magazines as One of America's Finest Inns

Lounge & Dining Room Available for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.

SPARKS 771-4366

11

Downtown Baltimore's most renowned Italian cuisine

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*



Your Host
Tom d'Anna

539-9021

10



SPECIAL AT THE

FABULOUS CLUB VENUS

An Evening for Two . . Only $15

Offer good every night except Saturday
Make Reservations Now

Perring Plaza Shopping Center—Beltway Exit 30

For Reservations Call **NO 8-2232**

5



Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS

Finest Sea Foods
Prime Meats

5653 Old Frederick Road

East of Ingleside Ave., off Baltimore National Pike

TED KUCHTA, *Manager*

Phone 744-0223

Fine Restaurants

Recommended for

Your Dining Pleasure

7

Miller Bros.

"The Place to Eat"



NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call **752-4822**

3

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

Baltimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center
Open 12 noon to 3 A.M.—Closed Mondays

For Reservations Call **685-2811**

2 blocks south of the Flag House

300 ALBEMARLE STREET

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

4

Broadview Restaurant

Cocktails • Dinners • Luncheons

Private Entertaining Facilities

116 W. University Parkway at 39th St.

CALL CH 3-1216

1

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD

Cocktails **Mexican Beers**

Tuesday thru Sunday

Open 5:00 P.M.---12:00 P.M.

Dinner and Snacks

Closed Monday

Phone 435-9858

9

Cork 'n Bottle Restaurant

STEAK — SEAFOOD — PRIME RIB

COCKTAILS

LUNCHEON — DINNER

Major Credit Cards Honored

Private Party Rooms

22 E. FAYETTE ST. BALTIMORE, MD.

½ Block from Charles Center

539-1268

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE

Baltimore 1, Md. **MU 5-6790**

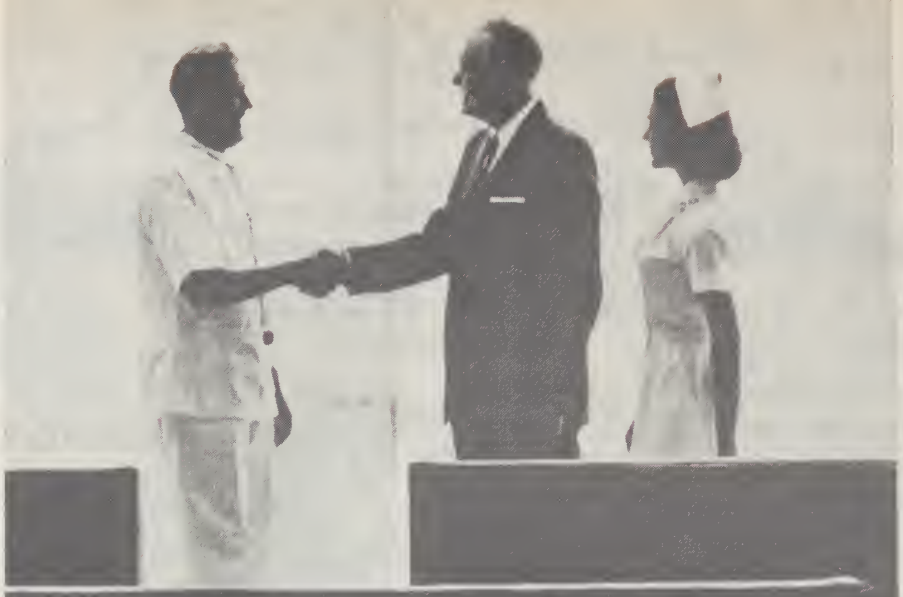
CARRY-OUT SERVICE

SPECIAL LUNCHEON and DINNERS

PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.

Sunday 12 Noon to 3 A.M.



More than 4,000 of Maryland's businesses choose BLUE SHIELD®

Who knows value better than those who buy insurance for leading corporations? It's no accident that an overwhelming majority of them select Blue Shield for their employees. In Maryland, more than 4,000 businesses have chosen Blue Shield protection for their employees. That adds up to more than one million Marylanders who carry the Blue Shield card today.

Without the sponsorship of your local medical society, Blue Shield could not exist. Without the devoted services of you and your colleagues who serve on Blue Shield Boards the country over, Blue Shield could not serve its members so economically.

To find out more about the basic value of Blue Shield to you as a doctor, just use the convenient coupon.

Maryland Blue Shield®

7800 York Road
Baltimore, Maryland 21203

Please send me my free copy of your booklet on Blue Shield.

Name_____

Address_____

City_____ State_____ Zip_____

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Growth of Day Care Centers for the Mentally Retarded

Neil Solomon, MD, Secretary of Health and Mental Hygiene, announced that departure from established procedure, a willingness to test new methods of training, and a firm belief that every individual has some capacity to learn, have characterized Maryland's program of Day Care for the Mentally Retarded. Established in 1961 as a complement to existing health services in the state, the day care program has grown and flourished as a community oriented activity.

Much of the strength and success of this statewide program are directly attributable to the effective use of nonprofessionals. This trend, which is beginning to develop in many areas, is commonly thought to be a result of the chronic manpower shortage. However, in Maryland, the use of nonprofessional personnel was an integral part of the entire day care plan.

This approach was adopted as a means of keeping day care noncompetitive with special education and preventing duplication of programs. The thinking was that, under close supervision, nonprofessional personnel could carry on basic, developmental training while supervision would be provided by state consultants and by center directors with professional backgrounds.

In the early stages of development, services for mentally retarded children and adults included no provisions other than institutional care for the more dependent individuals functioning on lower levels. However, many parents and professionals felt that this group could develop more fully in a home environment, with the help of a training program geared to their specific needs—needs which could not be met in existing, classroom-type facilities.

The first step toward exploring this possibility was made in 1961 when the Maryland General Assembly made state funds available for the development of community day care centers for the mentally retarded. The legislation stipulated that the State Department of Health would set operating standards and then make the funds available to counties on a matching basis. An additional key feature was that a private nonprofit corporation would be responsible for the operation of each local center. Membership of the Board of the operating group would consist of representatives from health, education, social services, parents and the community.

Community acceptance of the challenge is reflected by the ever increasing numbers of centers. Starting with the first center in 1961, 18 Boards of Directors are presently operating 32 centers located in 13 counties and Baltimore city, with another expected to open in the fall. Accompanying increases in enrollment and budget are shown on the chart, along with a projection for fiscal 1970.

BALTIMORE OXYGEN SUPPLY CO., INC.

OHIO CHEMICAL DISTRIBUTORS

Therapy and Medical Gases
and Oxygen Tents
Resuscitators and Apparatus

Main Office & Plant: Linthicum, Md. 789-8100
Warehouse: 1611 Guilford Ave., Baltimore, Md. 727-4748
Branch: 2426 Linden Lane, Silver Spring, Md. 582-2094

OFFICE SPACE AVAILABLE

in the

EMERSONIAN APT. BUILDING

For Rent—established office space. 2000 square feet, suitable for the accommodation of 3 physicians or less. Will remodel for 1, 2, or 3 physicians. Pleasant surroundings.

Phone 523-0410



MITCHELL'S

MARYLAND CORN!

Garden Flavor Guarded

F. O. Mitchell & Bro., Inc.
Perryman, Maryland

Phone Perryman 272-3636
Plant Phone
Perryman 272-3637

ALCAZAR SWIMMING POOL

Cathedral & Madison Sts.
Baltimore, Maryland

Phone: 837-8400

Heated Pool *Steam Room*

Our POOL and STEAM ROOM are available to patients who would like to exercise themselves back to Good Health!

Open Mon. thru Fri. *10 A.M. to 3 P.M.*
September thru May

Rates: $15.00 Yearly Membership

Call: Mr. D'Agostino

VOLVO 164.

New 4 door luxury sedan.

Luxury and comfort are unsurpassed. Included as standard equipment: POWER STEERING, 4 WHEEL POWER DISC BRAKES, ALL LEATHER BUCKET SEATS and the new 182 cu. inch engine. Air Conditioning and Automatic transmission are available.

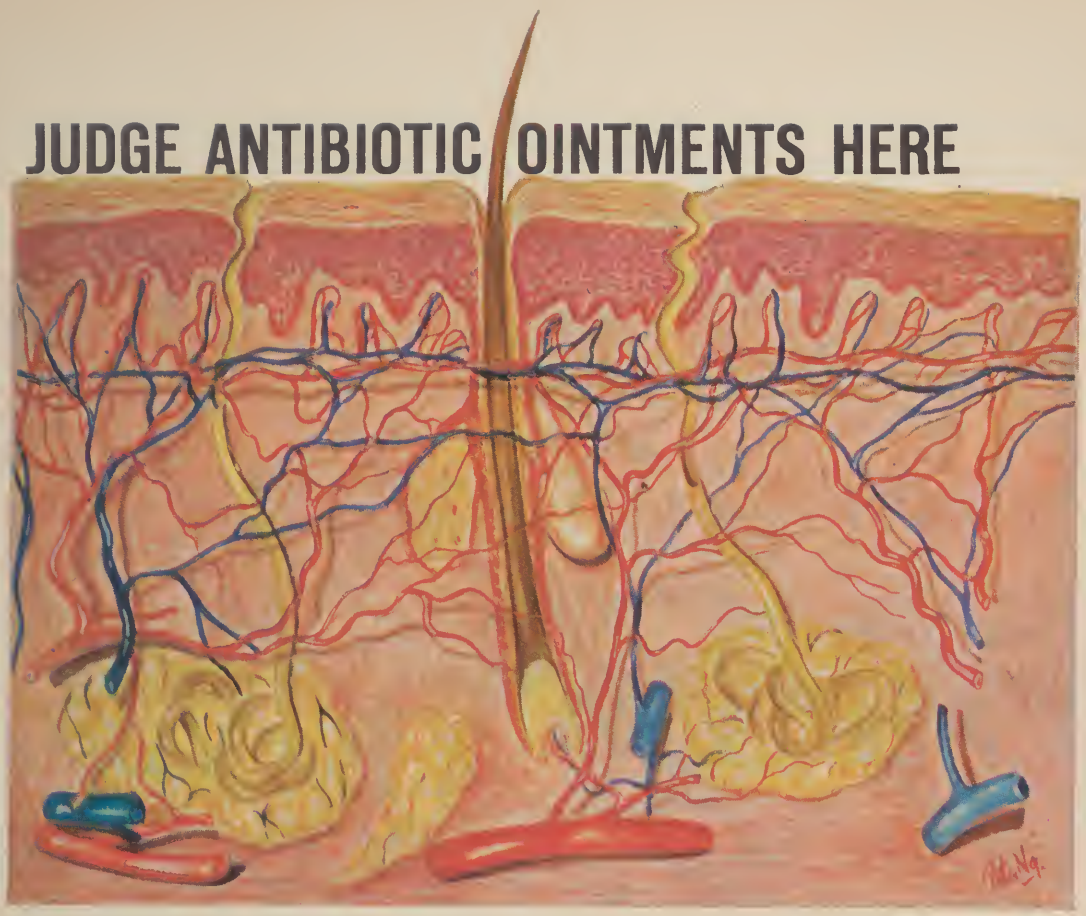


ASK ABOUT OUR FREE 24 HOUR DEMONSTRATION

VOLVO michaelson motors, inc.

5801 REISTERSTOWN RD. • 358-5800 • OPEN NITELY 'TIL 9:30

JUDGE ANTIBIOTIC OINTMENTS HERE



Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B—bacitracin—neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

'NEOSPORIN'®

brand

POLYMYXIN B-BACITRACIN-NEOMYCIN OINTMENT

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



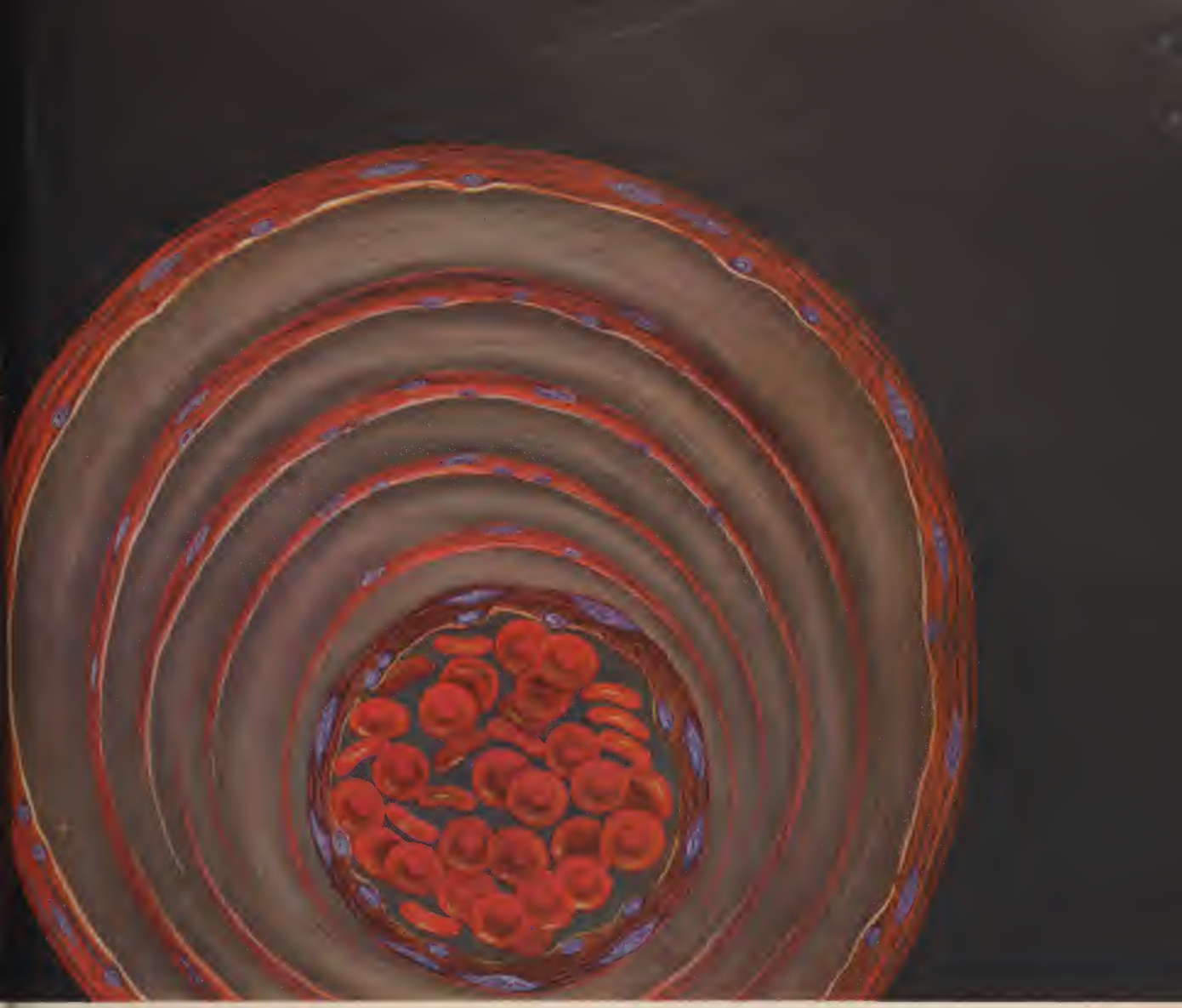
Because peripheral vasodilatio is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided sustained-release Roniacol Timespan (nicc alcohol tartrate) Tablets. Part of the drug b comes available immediately, the remaind continuously over a period of up to 12 hou and dilation of constricted peripheral vess usually maintained. Thus, with a single dos medication, patients can enjoy the benefit increased peripheral blood flow in ischem extremities for up to 12 hours.



mooth peripheral vasodilation from initial osage...extended with mple, well-tolerated, b.i.d. dosage

prolonged action of Roniacol Timespan otinyl alcohol tartrate) together with its er benefits offer a therapeutically practical sure in the long-term management of pheral vascular disease–advantages ecially important for older patients.

ore prescribing, please consult complete duct information, a summary of which ows:

cations: Conditions associated with cient circulation; e.g., peripheral vascular ase, vascular spasm, varicose ulcers, bital ulcers, chilblains, Meniere's syn- me and vertigo.

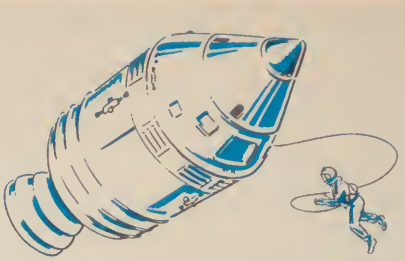
Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE
Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, 300 mg.; SODIUM ACID PHOSPHATE, 500 mg.

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



MRS. FRANK A. FARAINO, EDITOR

woman's auxiliary

Maryland Auxiliary Shares Spotlight at National Convention



Woman's Auxiliary representatives at the National Convention in New York City in July included: (from left) Mrs. R. Kennedy Skipton, 3rd Vice President; Mrs. Leonard G. Warres, Immediate Past President; Mrs. Wallace H. Sadowsky, President, and Mrs. Elmer G. Linhardt, 1st Vice President.

The 46th annual convention of the Woman's Auxiliary to the American Medical Association was held at New York's Waldorf-Astoria Hotel July 13-17, 1969. Among the 919 registered were the following members of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland: Mrs. Wallace H. Sadowsky, President; Mrs. H. Leonard Warres, Immediate Past President, Mrs. R. Kennedy Skipton, 3rd Vice President and Chairman of Delegates; Mrs. Elmer G. Linhardt, 1st Vice President and Delegate; Mrs. Harold P. Biehl, Alternate; and Mrs. James L. Garey, Alternate.

National Auxiliary president, Mrs. John M. Chenault, Decatur, Alabama, who presided over the sessions, said: "Let us direct our energy toward achieving better health conditions and use our imagination in developing projects and programs which will meet the health needs of our communities . . . As we work with our medical societies, let us be ready to stand up and be counted as we speak with pride for those things which are right with American medical practice."

Mrs. Chenault filled the unexpired term of her predecessor, Mrs. C. C. Long, Ozark, Arkansas, who died suddenly on April 22. Emotion choked the voices of the auxiliary members as they repeated in unison the 23rd Psalm at the memorial service where tribute was paid to Mrs. Long, the beloved, gallant leader who directed the activities of the auxiliary and had made all of the plans for the 1969 convention before her untimely death. In memory of Mrs. Long, a resolution on anti-violence in television and motion pictures was passed by the House of Delegates.

The Maryland auxiliary was the recipient of a Membership Recognition Award presented for "an outstanding membership program in 1968-69" by Mrs. G. Prentiss Lee, 1st Vice President of the national auxiliary.

Among the outstanding features of the convention were the new "Show and Tell" exhibits and films. Some 20 exhibits, illustrative of the imaginative programs conducted by Auxiliary members, were on display Tuesday, July 15. This allowed state and local auxiliaries to learn about one another's projects and provided an interchange of ideas. Mrs. Harold P. Biehl, Baltimore, Children and Youth Chairman, prepared a very fine exhibit entitled "Violence," which showed how the Auxiliary members in Maryland put forth efforts to rid television, radio, and movies of violence.

Also, among the "Show and Tell" films shown was one entitled "The Many Hats of Laurie and Harriet," sponsored jointly by the Maryland medical auxiliary, the Baltimore city medical auxiliary, the Maryland Nurses Association, and the Baltimore City Health Department. The film follows two public health nurses through a typical day of administering to the needs of patients in their assigned areas.

During the luncheon on July 14, Mrs. Chenault presented the Auxiliary's contribution to the American Medical Association Education and Research Foundation to Milford O. Rouse, MD, president of AMA-ERF. This year's record-breaking sum totaled $428,875.77, bringing the Auxiliary's total contribution since 1951 to $3,697,132.77. The Woman's Auxiliary to the California Medical Association received an award of merit for making the largest contribution to the program—$69,740.21. The total raised by the Maryland auxiliary from June 1, 1968 to May 31, 1969 was $5,795.18.

Ethel Alpenfels, PhD, Professor of Anthropology at New York University, addressed the assembly at the Tuesday morning session. She predicted that in five to ten years, society will require a physician who understands not only the physical and the medical facts, but who also understands human beings. "The medical profession today must begin to examine attitudes, its own as well as its patients'. To understand how a patient sees and how he acts is to understand the culture in which he lives," Dr. Alpenfels said.

During the Tuesday morning session, Henry C. Huntley, MD, director of the Division of Emergency Health Services for the department of Health, Education, and Welfare, U. S. Public Health Service, made a presentation of the Emergency Health Services Award to the Woman's Auxiliary to the Honolulu County Medical Society for its outstanding achievements in informing Hawaiian residents about various poisons.

Mrs. Charlotte Montgomery, author of the "Speaker of the House" column in *Good Housekeeping* and Vice President of the Women's Conference of the National Safety Council, presented a National Safety Council award to the Woman's Auxiliary to the Oklahoma County Medical Society for its "Teen Sitter Workshop" program which trained more than 2,000 teenagers.

Ann Landers, author of the world's most widely syndicated advice column and a member of the AMA's Advisory Committee on Health Care of the American People, was the guest speaker at the Tuesday luncheon honoring National Past Presidents, Officers, Directors and Committee Chairmen. Miss Landers cited some of the mail she receives from physicians' wives and mentioned some of their common problems.

"Lack of communication is the greatest stumbling block in most marriages. Men who run multi-million dollar corporations can't handle their kids . . . or think of anything to say to their wives. . . .

"We are paying dearly for our money-oriented culture. We know the price of everything and the value of nothing. . . .

"Young people aren't worse than we were, only different. But that must be expected because the world has changed so much in the last 35 years. They have the disadvantage of having too many advantages. Our culture has changed from the survival of the depression times to lack of motivation and new values. . . .

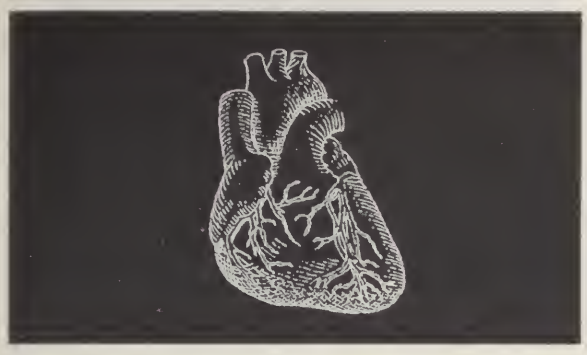
"Being a wife of a doctor is a tough assignment, but wives of other professionals have the same complaint, the most universal being the lack of communication."

In her inaugural address on Wednesday, July 16, Mrs. Chenault outlined a plan for carrying out her theme for the year, "Active Leadership in Community Health With the Accent on Youth." She urged the Auxiliary members to "study the health resources of the area in which they live and to evaluate the human resources with which they have to work." She encouraged Auxiliary members to work closely with their husbands and sponsoring medical societies to "raise the level of health care for all the people."

The Wednesday afternoon session concluded with a discussion on "Health Education Through Package Programs," followed by the showing of the film, "Escape to Nowhere." This film is the real life story of drug use told "like it is" by kids who use drugs. It is recommended for showing to senior high, college and adult audiences.

The report of the 46th annual convention of the Auxiliary to the American Medical Association by Mrs. R. Kennedy Skipton was read in Mrs. Skipton's absence by Mrs. Richard D. Bauer at the Board Meeting of the Maryland auxiliary held at the summer home of the president, Mrs. Wallace H. Sadowsky, Ocean City, Maryland on August 4, 1969.

Visit the #1 Spot for
Your Diet Needs
Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)
For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic
SPECIAL DIET SHOP
Phone SA 7-0383



JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Effect of Other Drugs on Oral Anticoagulants

LAWRENCE F. AWALT, MD
Senior Fellow-in-Cardiology
University of Maryland Hospital

Introduction

The use of oral anticoagulants remains popular for the treatment of thromboembolic problems. The need to closely monitor these drugs with the one-stage prothrombin time is widely recognized and practiced. There is wide variation in the response to a given dose of these agents. Inherited resistance to these drugs is a well documented phenomenon. The author has encountered one individual who (unfortunately there was no family available for study) required between 50 and 75 mg of sodium warfarin a day to maintain his prothrombin level in the minimum therapeutic range.

More common, however, but not always so well remembered, are the numerous other factors which effect the prothrombin time in the presence of oral anticoagulants. Weak and debilitated individuals, those with intestinal malabsorbtion, persons with chronic liver disease, acute alcoholism with or without chronic liver disease, as well as persons of very advanced age, all tend to have an increased sensitivity to the effects of oral anticoagulants. Accordingly, the loading dose and subsequent maintenance doses have to be adjusted downward from the average for these persons. Here again, however, there is wide variability.

The most frequent difficulties arise with the concomitant use of other drugs. These may be divided into those which potentiate and those which depress the prothrombin response to anticoagulants.

Potentiating Drugs

Aspirin is well known in this regard and is probably the most frequently encountered. Acetaminophen (*Tylenol*) has been proposed as an aspirin substitute, but this drug also has the same effect as its analog, aspirin.

The broad-spectrum antibiotics and sulfas, by depressing the vitamin K producing intestinal flora, tend to have this potentiating effect, but only occasionally to a striking degree.

Clofibrate (*Atromid-S*) usually strikingly prolongs the prothrombin time in the presence of warfarin. Therefore, the anticoagulant dose ought to be lowered by approximately 50% until the actual effect has been observed over a few weeks period, during which time the prothrombin time is measured at least weekly. This drug plus d-thyroxine and the anabolic steroid, norethandrolone, increase the effect of the coumarins apparently by altering the receptor sites for the drug, since serum levels are not increased or prolonged. Cortisone usually potentiates the coumarins. Phenramidol HCl (*Analexin*) was one of the earliest drugs noted to have this effect.

Phenylbutazone (*Butazolidin*) and oxyphenbutazone (*Tandearil*) are very frequently encountered problem drugs in this regard and reliably and strikingly affect the prothrombin time in the presence of warfarin. Phenylbutazone decreases the plasma half-life of warfarin by decreasing plasma binding and, in the process, makes more warfarin available for receptor sites, thus prolonging the prothrombin time.

Heparin, especially when given I.V., prolongs the prothrombin time just as warfarin, to some extent, prolongs the clotting time. However, the effect of heparin on the one-stage prothrombin time is of short duration, a fact which is useful in switching from heparin to oral anticoagulants. Peak prothrombin times occur at one to two hours after an I.V.

dose of heparin and quickly taper off to baseline levels by about four hours. Heparin given subcutaneously does not so noticeably affect the prothrombin time. Depending upon when blood is drawn for prothrombin determinations in relation to the time of administration of heparin, the prothrombin time obtained may be more a reflection of heparin activity than of coumarin activity, whereas a blood sample drawn a few hours later would reflect almost entirely coumarin activity.

Quinidine in some persons acts synergistically with oral anticoagulants to prolong the prothrombin time. There are several reports of this effect in the literature. It is probably uncommon, but certainly ought to be remembered in view of the frequent concomitant use of these drugs.

Drugs Which Diminish Sensitivity to Coumarins

Drugs which diminish sensitivity to coumarins are in widespread use. Vitamin K is a direct antagonist and hardly needs to be mentioned.

Some barbiturates, especially phenobarbital, increase the rate of coumarin metabolism by hepatic microsomal enzymes by the process of enzyme induction. This increases the amount of anticoagulant drug needed to achieve a given prothrombin time prolongation. An individual may require up to 33% more warfarin while taking 30 mg of phenobarbital Q.I.D. In the presence of phenobarbital, plasma coumarin levels are lower and thus it is inferred that increased metabolism is responsible for this effect. Secobarbital, on the other hand, has been shown not to have this enzyme stimulating affect.

It is interesting that other non-barbiturate hypnotics also have recently been shown to have the same effect, namely, glutethamide and chloral hydrate and its derivative, chloral betaine. However, chloral betaine, although it decreases plasma half-life of warfarin to a mild degree, does not very appreciably affect the prothrombin time. It is useful to note that, at least with phenobarbital, this phenomenon may take a week or more to first appear and may last for up to six weeks after this drug is discontinued. There is one recent report of hemorrhage associated with prolonged prothrombin time in an individual on bishydroxycoumarin, resulting when chloral hydrate was discontinued but the anticoagulant continued at the previous dose.

In summary, there are a variety of factors which affect an individual's prothrombin response to oral anticoagulants. One of the major factors is the concomitant use of other drugs. Whenever an individual is taking one of the oral anticoagulants, that is a coumarin or indandione (eg, *Miradon*) drug, particularly on a long term basis, it is necessary to monitor closely the use of other drugs. This is especially true when the anticoagulation is maintained by another physician.

SKILL SURGICAL, INC.

SUPPLIES & EQUIPMENT
for
PHYSICIANS–SURGEONS
HOSPITALS

5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

LDG
LUCAS DESIGN GROUP



Contract Interior Design Division of Lucas Bros., Inc.
221 East Baltimore St. ■ MU 5-3000

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

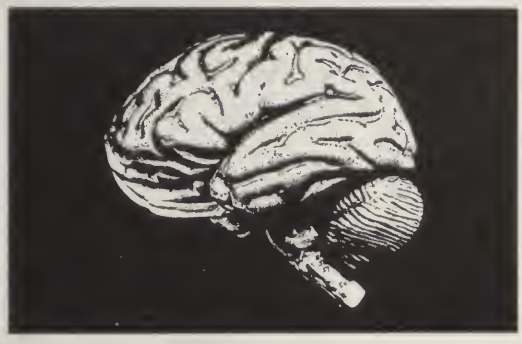
Prompt Pick-up and Delivery MU 5-3232

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202

BLOOD PLAN
of the
METROPOLITAN WASHINGTON
BLOOD BANKS, INC.
Not For Profit
A BLOOD DONATION TODAY
PROTECTS YOU AND YOUR
FAMILY TOMORROW

- A Medically Supervised Blood Benefit Program
- Individual—Family—Group Memberships

T. A. Loosbrock, Exec. Dir.
915 19th St. N.W., Suite 500 Phone 737-0060
Washington, D.C. 20006



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

A Report to the Fifteen Southern States*

Hospital services for the mentally ill in the Southern states have progressed substantially in recent years. Statistics published by the Office of Biometrics of the National Institute of Mental Health, show that despite this marked improvement the Southern states continue to lag appreciably behind the rest of the United States. The net difference in average daily per patient expenditure is now higher than it has been at any time previously, while the ratio of employees to patients continues to lag appreciably.

Average Daily Per Patient Expenditure	15 Southern States	Rest of United States	Net Difference	Percent Difference
1958	$2.87	$4.42	$1.55	– 35.1
1963	4.16	6.33	2.17	– 34.3
1967	6.43	9.68	3.25	– 33.6
1968	7.76	11.41	3.65	– 32.0
Number of Employees For Every 100 Patients				
1958	25.3	32.8	7.5	– 22.8
1963	33.1	39.6	6.5	– 16.4
1967	42.0	52.7	10.7	– 20.3
1968	46.1	54.9	8.8	– 16.0

Total hospital maintenance expenditures by the 15 states more than doubled in this ten-year period (from $139,000,000 in 1958 to $310,000,000 in 1968) and average daily per patient expenditures are now two and one-half times the 1958 figure. However, since comparable changes have occurred in the other 35 states, the South's relative position has remained essentially unchanged. In fact, the South's daily average in 1968 of $7.76 was exceeded by 10% or more by all except one of the other 35 states. The seven states with lowest per patient expenditures were all in the South. Arkansas, which had the highest per patient per day cost among Southern states ($13.93), ranked fifteenth nationwide. Related to this, the average size of the patient population declined 18.1% (from 133,198 to 109,073) in the Southern states during this ten-year span while the comparable figure for the rest of the country was 26.5% (from 413,139 to 303,745).

This disparity does not reflect a lesser interest and support for mental hospital programs. Rather, it is directly related to the relatively lower economic level of most Southern states. Latest figures released by the U.S. Department of Commerce indicate that per capita income in the South continues to be one fourth lower than in the rest of the United States. This in turn has produced lower than average per capita expenditures for all state services.

The South has been characterized as an area in transition. Gradual economic and social development can be expected to produce in the mental health field a concomitant continuation of the progress experienced in recent years. However, it must be recognized that unless this is rapidly accelerated, much of the South will perpetually continue to lag appreciably behind the rest of the United States.

* *Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia and West Virginia.*

DOCTORS' OFFICES

LARGE

MEDIUM

SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST. CORPORATION

11 E. Chase St.

Phone 539-8553

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION

ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE

DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily

Tuesday Evenings 7 to 9

355-9300

PATAPSCO AVENUE & FOURTH STREET

Baltimore, Maryland, 21225

AN EVENING WITH
VIRGIL THOMSON
and
ELAINE BONAZZI,
MEZZO-SOPRANO

TUESDAY 8:30 p.m.
OCTOBER 28, 1969

AN EVENING OF
PORTUGUESE MUSIC
with
THE PEABODY ORCHESTRA
ALVARO CASSUTO,
GUEST CONDUCTOR

TUESDAY 8:30 p.m.
NOVEMBER 11, 1969

THE PEABODY CHORUS
GREGG SMITH,
CONDUCTOR
music of
EARLE BROWN,
RESIDENT COMPOSER

FRIDAY 8:30 p.m.
JANUARY 16, 1970

PEABODY CONSERVATORY

CANDLELIGHT CONCERTS



Peabody Concert Hall
1 E. Mt. Vernon Pl.
Baltimore, Md. 21202
837-0600

THE MONTH IN WASHINGTON

A Food and Drug Administration advisory committee found oral contraceptives to be "safe," but reported that British and U.S. studies had established "an etiologic relation between thromboembolic disorders" and their use.

The Advisory Committee on Obstetrics and Gynecology, making its second report on oral contraceptives, said that their benefits outweighed the risks sufficiently to designate them "safe" within the intent of the federal law.

As for the potential carcinogeneity of oral contraceptives, the report said no conclusion could be drawn at this time.

The committee called for intensive research along three lines: ● possible relationship of hormonal contraceptives and carcinoma of the breast and uterus; ● determination of the basis and prognosis of metabolic alterations produced by hormonal contraceptives, and ● development of new methods of contraception.

The committee, in its initial report, three years ago, approved of oral contraceptives with reservations. It now said that these reservations appear to have been justified because of the adverse reactions reported in both scientific literature and the general press. But the report concluded:

"When these potential hazards and the value of the drugs are balanced, the committee finds the ratio of benefit to risk sufficiently high to justify the designation safe within the intent of the legislation (Kefauver-Harris Amendments of 1962)."

The report said scientific studies "suggest that the mortality from thromboembolic disorders attributable to the oral contraceptives is about three per 100,000 women per year, adding less than 3% to the total age-specific mortality in users of these drugs." In a U.S. study, the risk of thromboembolism to a woman using hormonal contraceptives was estimated by indirect methods to be 4.4 times that of a nonuser.

It was stated in the report there is no evidence that any metabolic alterations induced by the oral contraceptives pose serious health hazards.

The effectiveness of oral contraceptives was found to be significantly higher than for intrauterine devices or traditional methods.

* * *

Abandoning a long court fight, **the Internal Revenue Service reversed itself and ruled that organizations of physicians authorized under state professional association laws will be treated as corporations for tax purposes.**

The IRS announced that it would not appeal to the Supreme Court two recent decisions by U.S. courts of appeal favoring the professional association. In accordance with these court decisions, the IRS said, "organizations of doctors, lawyers and other professional people organized under state professional association acts will, generally, be treated as corporations for tax purposes."

Forty-two states have such laws which offer tax benefits, including deferment of the tax on pension plan contributions until retirement.

The court controversy over IRS treatment of the professional associations for tax purposes dates back to the early 1950's. It was given a "Kintner" label in 1954 when an appeals court ruled in favor of the professionals in a case brought by Arthur Kintner, MD, Missoula, Montana.

* * *

The federal government has started a program designed to increase enrollment in the nation's schools of medicine and osteopathy by 4,000 over the next four years.

Known as the **Physician Augmentation Program,** the activity, under the Department of Health, Education and Welfare, supports the addition of 1,000 first-year places commencing with the fall term of 1970. These places are in addition to any increase to which the schools have already committed themselves. Total enrollment through this program is expected to be about 4,000 in the fourth year of operation. The Physician Augmentation Program is authorized under the Health Manpower Act of 1968.

Grants will be awarded on a national competitive basis to those schools of medicine and osteopathy that document their intention to institute a major increase in their first-year enrollment and that appear to have the greatest potential for achieving major increases with their own resources as supplemented by funds allocated by the program.

* * *

Robert H. Finch, secretary of Health, Education and Welfare,

proposed that state medicaid administrators work more closely with state medical societies on cost control in the federal-state health care program.

He also said that the states should review more claims in efforts to control medicaid costs.

Finch gave his views on controlling medicaid costs in a letter to Sen. Abraham Ribicoff (D., Conn.) who had asked what was being done and what additionally could be done about rising expenditures in the program.

In answer to a question as to what states "could be doing under existing law to control medicaid costs more efficiently," Finch said:

"One answer is to spend more money on the claims review function. For example, there are two states where annual medicaid expenditures are in excess of one hundred million dollars. One employs 7 people for its review function, the other employs 70. The latter state has very effective control over costs and utilization.

"But I am coming to believe that a major factor is the degree to which physicians are involved in the program, not simply as purveyors of medical care but also as watchdogs of costs and guardians of quality. They generate the bulk of medicaid expenditures. They authorize admissions to hospitals and skilled nursing homes and they write prescriptions. The need for genuine physician participation in controlling costs is self-evident. A state medicaid administrator would be well advised to make extensive use of his medical advisory committee and to engineer the plan in detail through the state medical society."

As to what states already are doing, Finch said:

"Some states are using prior authorization of service (emergencies excepted). Some use fee schedules. Some use audit tolerance levels. Some incorporate parameters of medical care into their data processing systems. Some develop client and purveyor profiles. Some use computers to process claims. Others contract the review function to a fiscal agent, eg, a Blue Cross plan. Some use a medical audit and some have been doing very little."

Ribicoff said in his letter to Finch that he understood "there is very uneven performances of medicaid program review throughout the nation."

Peer review, under leadership of state and county medical societies, has top priority in the American Medical Association recommendations for controlling costs in both medicaid and medicare. A report of the AMA board of trustees approved by the house of delegates at the 1969 annual convention in New York strongly urged that:

—"Peer review be assigned the highest priority by the

You ARE CORDIALLY INVITED TO INSPECT
THE ALL NEW PRODUCTS FROM FORD FOR 1970 AT

TOWER FORD

BALTIMORE'S LARGEST FORD DEALERSHIP CONVENIENTLY LOCATED
JUST ONE MILE EAST OF JOHNS HOPKINS MEDICAL CENTER
COMPLETELY EQUIPPED SERVICE and PARTS CENTER FEATURING OUR
ELECTRONIC DIAGNOSTIC AUTO ANALYZER
THAT PERFORMS OVER 100 SERVICE CHECKS FOR ONLY $9.95
CHOICE SELECTION OF NEW and ONE-OWNER 1969 MODELS
AT TREMENDOUS SAVINGS

LONG TERM LEASING – DAILY & WEEKLY RENTALS



TOWER Ford

3700 E. Monument St.
675-5515 (Just East of Edison Hwy.)

New and Used Car Depts. Open Daily and Saturday 9 to 9 — Service Depts. Daily 7 to 6. Closed Sat.

state and county medical societies; that where existing mechanisms exist, they be strengthened, and where they do not, they be promptly established.

—"Quick and decisive action be taken, in appropriate fashion, to discipline those few physicians determined, after investigation, to be abusing medicare and medicaid, either fraudulently or otherwise."

The AMA recommendations for cost control in government health programs also include:

—"The promotion of innovative health service delivery systems for low-income communities with emphasis on ambulatory care.

—"Programs by local medical societies to insure preservation of quality health care in the face of cost containment measures."

Taste!

Dicarbosil®
ANTACID

Your ulcer patients and others will love it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.



ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Advertisement

AN ANNOUNCEMENT TO MARYLAND PHYSICIANS WHOSE PATIENTS HAVE CHRONIC SLEEP DISTURBANCE

Recent advances in sleep research have made it possible to measure a variety of sleep disorders in otherwise normal patients.

To further these studies a clinic is being established at the Maryland State Psychiatric Research Center under the direction of Dr. Clinton Brown, Chief of Basic Sciences Research.

The primary purpose of this clinic will be to investigate the variables producing insomnia so that more effective treatment approaches may be formulated.

Of interest are: 1) the personality configuration, 2) sleeping habits and 3) psychophysiologic reactivity of the patient with chronic complaints of inability to fall asleep, frequent or early awakenings, somnambulism, enuresis or nightmares.

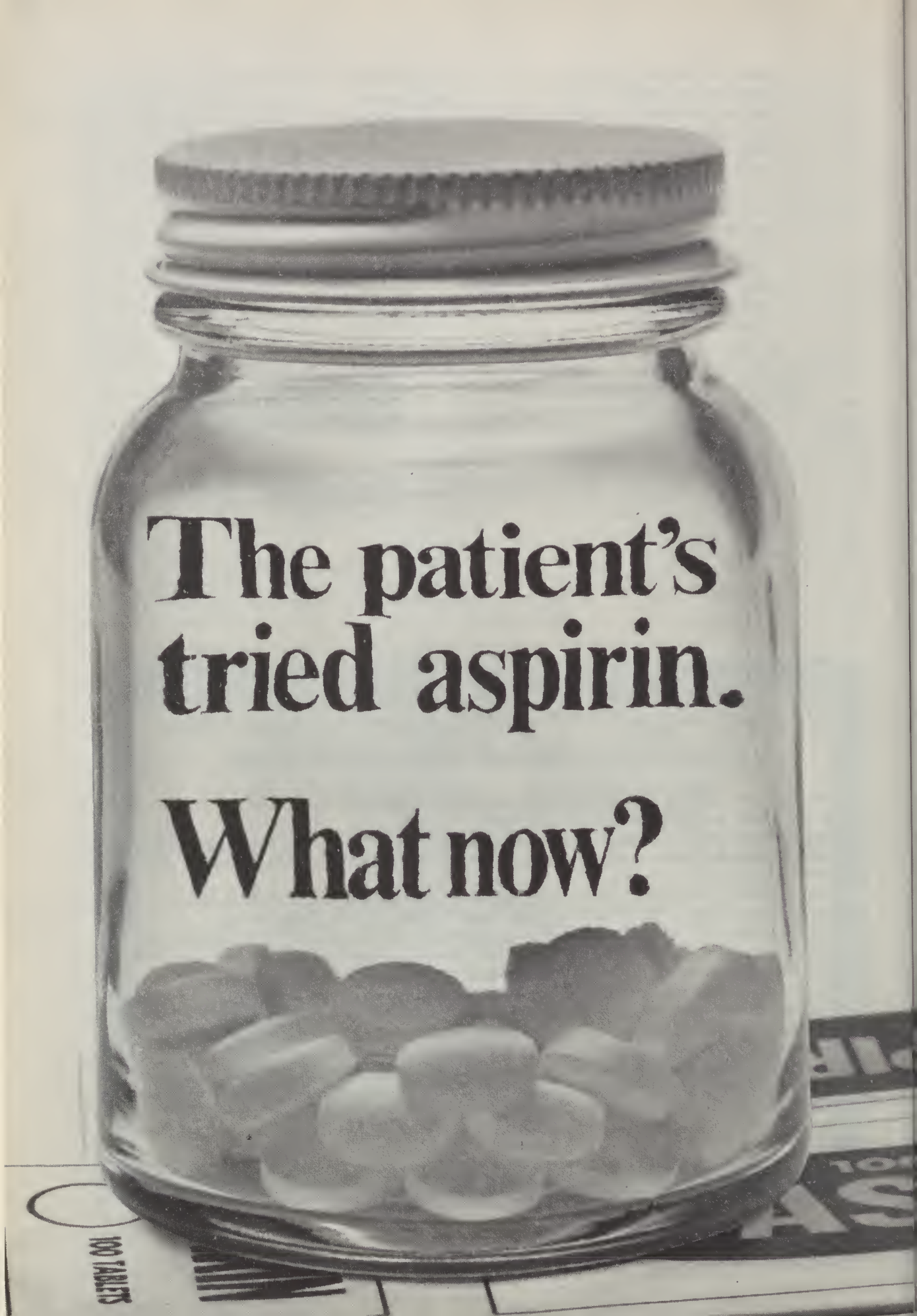
Individuals accepted for study will be given a physical exam, interview, psychometric test and polygraph recordings obtained during sleep.

Patients will be accepted by referral only and a diagnostic report will be furnished to the referring physician at the conclusion of the study.

Partial support for this project is being furnished by Friends of Psychiatric Research, a non-profit research foundation. While fees will not be charged, voluntary contributions by patients to offset study costs will be welcomed.

Additional information or appointment may be obtained by calling Mrs. Zaborowski at 744-8700, Ext. 252, 10 A.M. to 4 P.M. Monday thru Friday.

Albert A. Kurland, M.D., Superintendent.


The patient's
tried aspirin.
What now?
100 TABLETS

There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

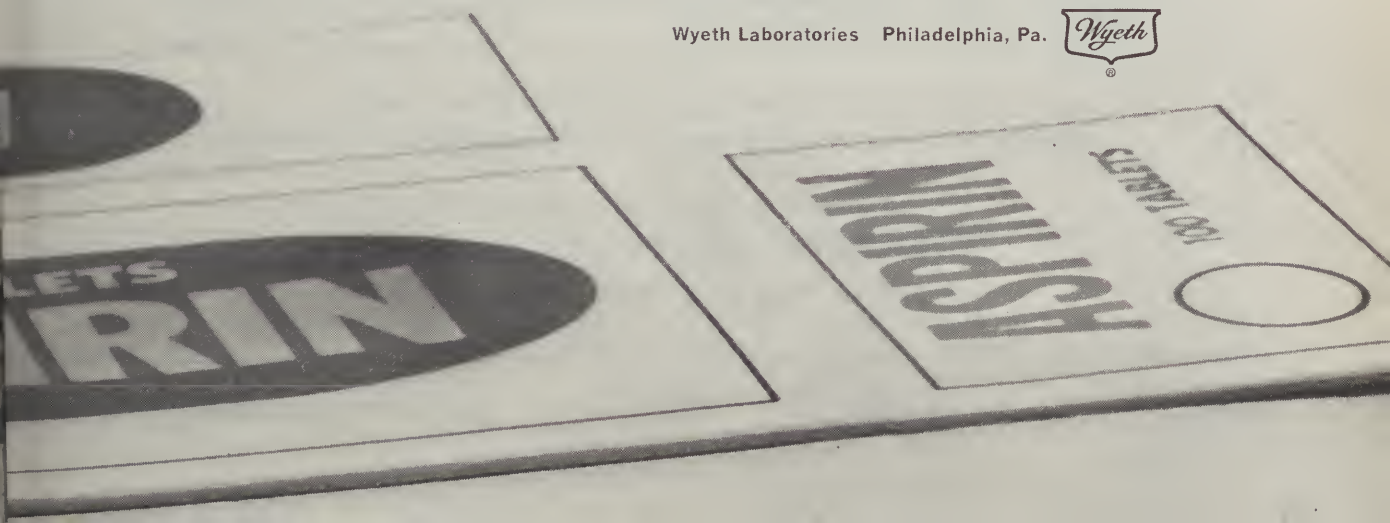
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



STATE-SUN FEDERAL

Savings & Loan Association

with locations at

809 N. HOWARD ST. 728-4640

and

8200 HARFORD RD. 668-1400

MORTGAGE LOANS • CONSTRUCTION LOANS

High Quarterly Dividends: Paid March 31, June 30, September 30 and December 31

Savings Received on or Before the 10th
Receive Dividends from the 1st

Member: Federal Savings & Loan Insurance Corporation, an instrumentality of the U.S. Gov't; Federal Home Loan Bank

SAVINGS INSURED UP TO $15,000

CONTINENTAL . . .



The Professional Man's Car
FROM MONARCH
Where the Customer is King
KING SIZE COURTESY, SERVICE, SAVINGS PLUS

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

PROFESSIONAL LEASING
Special low rates for our medical customers. Call or stop in.

MONARCH

COUGAR MERCURY MONTEGO CONTINENTAL
5525 BALTIMORE NATIONAL PIKE
Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • OPEN 9-10 • SAT 9 TIL 9 • CLOSED SUNDAY

HIGHLAND HOSPITAL

Asheville, North Carolina
Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: Mrs. Elizabeth Harkins, ACSW, *Coordinator of Admissions*

or

Charles W. Neville, Jr., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—254-3201



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

Rehabilitation of Spinal Cord Injured Patients

Part I: General Introduction

FLORENCE I. MAHONEY, MD
Chief, Physical Medicine and Rehabilitation Service
Veterans Administration Hospital, Baltimore
Formerly Director, Rehabilitation Medicine
Chronic Disease Hospitals
Maryland State Department of Health

Prior to World War II, the outlook for survival of spinal cord injured patients was indeed dim. This condition was described in what is believed to be the oldest medical textbook, "The Edwin Smith Surgical Papyrus", as follows:

"Thou shouldst say concerning him; One having a dislocation in the vertebra of his neck while he is unconscious of his two legs and his two arms and his urine dribbles. An ailment not to be treated." [1]

Management of spinal cord injury patients did not improve appreciably until World War II. During the Balkan Wars of 1912-13, mortality within a few weeks of injury was 95%. The large number of paraplegics, resulting from gunshot wounds, following World War I stimulated both the professional and public concern about these helpless veterans. An estimate of paraplegic mortality among British soldiers during the war was 80%; 47% of the deaths occurred in the first six weeks following injury.[1] The principle cause of death, as it is today, was due to complications of ascending urinary tract infections and decubitus ulcers.

When antibacterial therapy was discovered, the survival rate of the spinal cord injured patient increased. It was at this time that interest developed in the care of these patients. At first the clinical interest was in the care of the urinary tract infections and complications, prevention and care of decubitus ulcers, spasticity, pain, and what was then called myositis ossificans, but is now usually referred to as heterotopic ossification. Very soon the physical rehabilitation of these patients became a part of their comprehensive care since the functional capacity of the patient to care for himself was a major problem.

Thus, during World War II, considerable interest developed in the rehabilitation of the spinal cord injured patient. Munro, one of the early workers in this country, stated in 1945 that: "if he has been properly treated, every patient who has a spinal cord

In the next issues, we will have several articles on spinal cord injuries. The number of such injuries is gradually increasing with the increasing number of automobile accidents, bullet wounds, and other traumatic accidents of an industrial society. We are fortunate to have Dr. Florence Mahoney start off the series since she has had long experience with this condition and was one of the first doctors in Maryland to accumulate experience with a large number of these patients.

or cauda equina injury, who is intelligent and cooperative, and who has the use of the shoulder, arm, and hand muscles can be made ambulatory; can have such control of the bladder and bowels as to sleep through the night without either getting up or wetting himself; and carry out ordinary activities throughout the day without soiling himself with feces or having to evacuate his bowel oftener than every three hours; lead a normal social life, and within the limits of his intellectual capacity, can earn a satisfactory living." [2] Dr. Munro also emphasized the importance of team work between various physicians and surgeons, as well as nurses, physical therapists and social workers as being necessary to accomplish this goal with such patients.[3] He strongly urged that one physician should assume control of, and responsibility for, the over-all care, suggesting that "the one most enthusiastic, willing to give the necessary time, has the best general knowledge of the problems involved, and is willing to watch constantly the small details of therapy" should be in charge.

There has been considerable clinical study and development of the teamwork necessary to rehabilitate these patients since that time. In this country, some of the earliest work to develop techniques of activities of daily living (ADL) and ambulation was done by Dr. George Deaver of New York, who has been called the "Father of Modern Rehabilitation." [4] Following World War II, a number of paraplegic centers were established across the country in Veterans Administration hospitals. Many of the early studies were done in these centers by Bors, Comarr, Talbot and others, as well as Guttman in England. The Veterans Administration has published a selected bibliography on this subject covering the major publications from 1940-1963 [5] and a supplement covering papers written from 1964-1965.[6] A perusal of these volumes indicate the early emphasis on clinical problems, the development of the rehabilitation techniques, and the preserving of what was practical and useful as time went on. During the 1950's and 1960's, many rehabilitation centers and departments of physical medicine and rehabilitation or rehabilitation medicine have been developed in medical schools and hospitals. In these centers, spinal cord injured patients have been successfully treated with the end result of improvement of physical and mental health, and a return to society and useful work. Along with the improvement in treatment and rehabilitation techniques, more physicians have been attracted to the specialty of physical medicine and rehabilitation, and physical therapists, occupational therapists, nurses and social workers have developed a greater understanding of the total problem in treating patients with this catastrophic problem.

During this period of development of the specialty of rehabilitation, it has been learned that much can be done for the quadraplegic patient. Patients with cervical injuries at the level of C-6, who have paralyzed hands but preservation of the muscle power of sufficient strength in the trapezius, deltoid, pectoralis major (or at least a portion of it), biceps and radial wrist extensors, have been trained to be completely independent in a wheelchair. These patients can live at home without the help of a second person. With a few adaptations to the home, they are able to care for their bowels and bladder without help, take a shower, move in and out of bed, on and off the toilet, and in and out of a car, dress themselves completely, and even work in a place into which they can get their wheelchair. They can be bowel and bladder trained so that they will not soil themselves and can care for the colostomy bag if they have had a urinary diversion operation. They can write and type with a simple device which they can carry in their pocket and put on without assistance. No devices are needed for feeding or dressing. Four such patients (who were trained at Montebello State Hospital) are working in the Maryland State Office Building.

Some rehabilitation centers have been developing complicated assistive devices for quadraplegics with high lesions so that they can do a few things for themselves, such as feeding, wheeling a chair (electric or hand propelled), and writing. These assistive devices are used mainly for patients with too little muscle power to do these things in any other way.[7]

If successful rehabilitation is to be accomplished without unnecessary complications, care must be taken at the time of the accident and in the acute hospital. Patients must be handled properly at the time of the accident and in the emergency room to prevent further injury at the site of the injury.[8] In the operating room, and while the patient is in the acute hospital, care must be taken to prevent decubitus ulcers. Proper urological care must be instituted immediately to prevent unnecessary complications of the urinary tract.[9]

When the patient passes the acute state, he is usually transferred to a rehabilitation center or hospital, since he requires a highly sophisticated team, each of whom is well trained in the meticulous details of his specialty. Each member of the team needs to know the total problem of the patient, and all must work closely together under the direction of the physician in charge.

Factors Affecting the Final Goal in Rehabilitation

What can be accomplished with any given patient who has spinal cord injury will depend on three factors: 1. the amount of permanent damage done at the time of the accident; 2. the complications which develop contraindicating exercise; and, 3. the psychological response of the patient and his family to the catastrophic physical alteration.

Amount of Permanent Damage

Automobile accidents, falls, gunshot wounds, blows on the neck or back, and stab wounds are the most common causes of permanent injury. Most often, these injuries occur to young men—from the teen years to the early thirties.

The higher the lesion, the less independence the patient can achieve. If the injury is at C-4 and is complete, only the diaphragm is innervated from the cervical area. At C-5, the biceps and shoulder muscles are preserved. These patients will need nursing care, dressing and lifting, but the patient with a C-5 lesion should be able to put on his shirt, wash his face, comb his hair and feed himself, using assistive devices. Patients with lesions at C-6, as mentioned above, retain innervation of sufficient muscles to become independent in a wheelchair with proper training, no serious complications, and much patience on the part of the staff working with the patient. These patients, particularly if not obese, and if willing to invest themselves in the long tedious process, can return to society as a useful citizen. If they are bright and well motivated, they can be trained for a good job. Any patient with a cervical lesion below this level should become independent in all activities from a wheelchair with more ease, since he will have some innervation of the finger and thumb muscles. Those who have incomplete lesions vary in what they can accomplish depending on which muscles are preserved.

Lesions in the thoracic and lumbar area do not involve the brachial plexus and such patients should have no difficulty in becoming independent in a wheelchair. Those with lower thoracic or lumbar lesions can learn to ambulate with crutches and long leg braces as mentioned by Munro in his writing during the 1940's. However, few of them continue to walk after discharge from the rehabilitation center or hospital since the energy cost is too high. Those who continue ambulation are mostly thin, strong, young men who feel it is important to exercise, or those who have incomplete lesions and therefore some useful muscle power in the lower extremities. Those who go to work usually prefer to save their energy for this purpose.

Complications

Complications which most frequently interfere with these goals are decubitus ulcers and urinary tract infections. In some patients severe spasticity, heterotopic ossification and pain will be so severe as to interfere with rehabilitation. Body build, particularly obesity, may prove to be an added disability in the training of the patient.

Decubitus ulcers should be prevented from the time the patient is injured, through his acute hospital stay and during his rehabilitation. If they are allowed to develop, the rehabilitation time may be prolonged months to years.[10]

Urinary tract infections can be minimized if the physician who first sees the patient is well informed about the care of the neurogenic bladder and, therefore, treats it properly at the time of the accident and during the acute phase, and if the patient learns to drink plenty of fluids each day.[11] If the bladder remains atonic or reflux develops, he cannot be bladder trained, but must continue to wear a catheter. More recently the ileal loop bladder operation has been performed on some of these patients, especially if they have considerable and frequent trouble with urinary tract infections, reflux or an atonic bladder. According to Comarr, 80% of spinal cord injury patients can become catheter free within a year, and about two thirds of these can do so in six months after injury. However, he stresses that "the physician who cares for the neurogenic bladder must have patience. It requires time for a bladder to achieve balance so that an indwelling catheter can be removed permanently."[12] It is important to remember that the urological responsibility for the paraplegic and quadraplegic patient does not end when the patient is catheter free. At least yearly check-ups should be done on these patients if they are to keep well, since hydronephrosis, calculi of the kidneys or bladder or pathological changes in the urethra or genitalia may occur.

Obesity can be another disability in a spinal cord injured patient, since he needs to lift extra weight with fewer muscles. If the quadraplegic patient is short and stocky, it may prevent the independence that he might otherwise be able to attain. This is particularly true if he has short arms, even though he may have the necessary muscle innervation to expect independence in activities of daily living from a wheelchair.

Since most spinal cord injuries occur in young people, it is rare that heart disease and other medical problems preclude the necessary strenuous exercise to train the patient in activities of daily living. In older patients there may be medical complications which will make it impossible to do the activities necessary to allow independence.

A moderate amount of spasticity is helpful to the patient. It will assist him in activities of daily living and assist with emptying of the bladder. If spasticity becomes severe, the patient may go into extension or flexion as he attempts to move, and thus interfere with training in activities of daily living. If decubitus ulcers are allowed to develop, spasticity will be more severe, since ulcers are a strong stimulus to facilitation.

The etiology and pathology of osteoporosis is not understood. It becomes a problem in this type of patient when it is severe. The development of heterotopic ossification sometimes becomes a severe handicap in rehabilitation which challenges the orthopedist.

Psychological Factors

One of the most important factors in the rehabilitation of patients with spinal cord injuries is the psychological reaction of the patient and his family to this catastrophic and sudden change in his life, which has rendered him unable to move about normally, unable to feel below the level of the lesion and unable to control his bowels and bladder. All who work with these patients must understand the importance of focusing attention on a psychologically impaired person as well as a paralyzed patient. How the patient and family react to this severe loss depends in a large part on how they have learned to cope with life's many problems and the interaction of the patient's self-image and the response of others to him.[12] As rehabilitation techniques have developed and the care of the paraplegic and quadraplegic has improved, it has become increasingly evident that the treatment program should be further amplified with more meaningful understanding of the psychological and social problems which these patients face. As a result, rehabilitation centers have added psychological and psychiatric services to their staff and social service is an essential part of the team as well. In the acute phase there is a normal depressive reaction during which time the patient is assessing his loss, shifting his thinking, and evaluating what he has left with which to work. At this time he needs the greatest understanding and support by the nursing service in order to prevent decubitus ulcers, force his fluids, even at times to eat his meals. As soon as the patient can be up in a wheelchair and start learning activities and get around the hospital in his wheelchair, he begins to take a more realistic view of what he can expect to attain through rehabilitation. While he is still bedridden this is usually impossible for him, and he will talk about very unrealistic goals. It usually does little good to work out final goals for a patient until he has worked at ADL long enough to understand his assets and comes to grips with his rehabilitation activities. One need not be concerned with the early depression, except to give the proper psychological support and good medical care. However if the denial of disability persists, the patient will probably be a poor rehabilitation risk.

One must never underestimate the power of the helpless in dealing with these patients. Doctors, nurses, families and friends are easily threatened by the patient's inability to do things for himself, and the patient may learn quickly to manipulate all who work with him. It is for this reason that the patient does best in a rehabilitation setting working with a sophisticated team, all of whom are trained in the many facets of the spinal cord patient, and each a specialist in his particular part of the rehabilitation program. Firmness and understanding are part of the treatment. Communication between the various members of the team working with the patient help to bring this about, and assist the patient in finally learning his assets and working with them. Through good staff communication the team learns to distinguish between what the patient says and what he does, and thus avoids encouraging the patient to substitute what he calls "hope" for reality.

Summary

The care and rehabilitation of the spinal cord injured patient is a lifelong, meticulous and complicated procedure. It involves a thorough understanding of all the medical, rehabilitation and psycho-social problems on the part of the physician in charge and his team of ancillary personnel as well as the full cooperation of the patient if he is to reach his highest goal of physical, social and vocational rehabilitation. During the rehabilitation process the patient often grows to a more mature approach to living, in which case he takes care of himself without unnecessary help, prevents complications or at least minimizes them, manages his bowels and bladder with only rare accidents, and leads a normal social life within the limits of his disability. If he is intelligent and well motivated, he retrains for a new job if necessary and works. The physical rehabilitation is probably the most easily accomplished. Psychological adjustment and social and vocational rehabilitation are more difficult for many of these patients and usually requires a longer time.[13]

REFERENCES

1. Breasted, cited by, Abramson, A. S.: Modern Concepts of Management of the Patient with Spinal Cord Injury, *Arch PM and R* **28:**113, 1967.
2. Munro, D.: The Rehabilitation of Patients Totally Paralyzed Below The Waist, with Special Reference to Making Them Ambulatory and Capable of Making their own Living. I. Anterior Rhizotomy for Spastic Paraplegia: *NEJM* **233:**453, 1945.
3. Munro, D. Treatment of Injuries to the Nervous System. W. B. Saunders Co. Philadelphia, 1952. Pg. 56.
4. Abramson, A. S.: The Pioneering Role of the Early Clinicians, *Arch PM and R* **50:**334. 1969.
5. Spinal Cord Injury: A Selected Biblography 1940-1963; Medical and General Reference Library. Department of Medicine and Surgery, Veterans Administration. Washington, D.C., Jan. 1965.
6. Spinal Cord Injury: A Selected Bibliography. Supplement. 1964-1965. Medical and General Reference Library, Department of Medicine and Surgery, Veterans Administration, Washington, D.C., Sept. 1966.
7. Symington, D. C. and Mackay, D. E.: A Study of Functional Independence in the Quadraplegic Patient. *Arch PM and R* **47:**378, 1966.
8. Kuntz, J. and Carroll, D.: Total Management of Severe Spinal Cord Injuries, *Arch PM and R* **43:**494, 1962.
9. Comarr, A. E.; The Practical Urological Management of the Patient with Spinal Cord Injury. *Brit J of Urology* **31:**1, 1959.
10. Wood, O. W.: The Prevention and Treatment of Decubitus Ulcers, *Md State Med J* **7:**265, 1968.
11. Comarr, A. E.; Practical Management of the Patient with Traumatic Cord Bladder, *Arch PM and R* **48:**122, 1967.
12. Fordyce, W. E.: Psychological Assessment and Management, in Krusen, F. H., Kottke, F. J. and Ellwood, P. M. Handbook of Physical Medicine and Rehabilitation: W. B. Saunders, 1965. p 137.
13. Cogswell, B. E., Self Socialization. Readjustment of Paraplegics in the Community, *J of Rehab* **34:**11, 1968.



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

HELP!

Recently the American Hospital Association published results of a hospital library survey, which showed the following data concerning the need for more space in library quarters all over the nation.

Projections from the National Hospital Panel Survey
February, 1969

	Number of Hospitals	Number of Beds	Current Library Sq. Ft.	Library Square Feet Needed in 1970	Net Square Feet Increase
All Community Hospitals	5,872	772,503	4,652,225	6,223,606	1,571,381
Hospital Size					
6-24 beds	547	9,090	16,946	21,196	4,250
25-49 beds	1,439	51,350	172,087	238,384	66,297
50-99 beds	1,484	103,501	929,514	1,010,423	80,909
100-199 beds	1,139	158,467	1,019,442	1,284,540	265,098
200-299 beds	567	136,925	773,137	911,345	138,208
300-399 beds	302	102,482	440,326	735,354	295,028
400-499 beds	154	68,195	259,910	369,268	109,358
500+	240	142,493	1,040,863	1,653,096	612,233
Region					
New England	302	45,649	176,950	242,866	65,916
Middle Atlantic	698	159,340	703,445	927,789	224,344
South Atlantic	792	102,813	460,970	836,416	375,446
East North Central	930	154,180	547,118	851,589	304,471
East South Central	468	46,031	201,778	415,470	213,692
West North Central	774	77,100	878,175	1,052,268	174,093
West South Central	819	70,466	684,453	748,294	63,841
Mountain	347	29,480	46,000	74,950	28,950
Pacific	742	87,444	953,336	1,073,964	120,628

Physical space for housing personnel, as well as the book and journal collections, is the big problem in all libraries these days. The need is surpassed only by the lack of trained personnel to man the various positions necessary to operate libraries efficiently. Most medical libraries are forced to accept either untrained assistants or reduce services to their patrons. Usually, this means bibliographical effort is the first service to suffer, and in a library such as ours, serving an entire state, with physicians often unable to visit the library personally, such efforts are vital to satisfy the physicians' needs.

The Maryland area falls in the Middle Atlantic group which ranks third in net square feet increase needed by 1970. Fortunately, all new hospitals are planned to include some, if not always adequate, space for the medical staff and nursing school libraries. Others should provide enough footage and personnel to provide the maximum service possible under existing circumstances.

We know, we're caught in the squeeze like so many of our friends!

New Accessions

BOOKS

(Arranged by Author and Title)

Air quality monographs. #69, 1-11.
New York, American Petroleum Institute, 1969.

Alvarado, Raphael R.
X-ray technology examination review book. 2nd ed. Flushing, N.Y., Medical Examination Pub. Co., 1968.

American Association for Health, Physical Education and Recreation.
Special fitness test manual for the mentally retarded. Washington, AAHPER, 1968.

American Medical Association. Committee on Aging.
Health aspects of aging. Chicago, AMA, 1965.

Baltimore City Health Department. Mental Health Services.
Directory of mental health and mental retardation services. Baltimore, Baltimore City Health Department, 1969.

Beaumont, George Ernest.
Recent advances in medicine. London, Churchill, 1968.

Becker, Howard Saul.
Boys in white. Chicago, University of Chicago Press, 1961.

Bickerstaff, Edwin R.
Neurological examination in clinical practice. 2nd ed. Philadelphia, F. A. Davis, 1968.

Bourne, Geoffrey Howard.
The structure and function of nervous tissue. New York, Academic Press, 1968.

Bulletin of prosthetics research. BPR 10-8—spring 1967. Washington, Superintendent of Documents, U.S. Govt. Print. Off.

Cassinari, Valentino.
Central pain. Cambridge, Mass., Harvard University Press, 1969.

Conference of Coordinators of Regional Medical Programs, Arlington, Va., 1968.
Papers presented. Washington, U.S. Public Health Service, 1968.

Conference on Research on the Psychological Aspects of Aging, Bethesda, 1955.
Psychological aspects of aging, proceedings. Washington, American Psychological Association, 1956.

Conference sponsored by the National Interagency Council on Smoking and Health, College Park, Md., 1966.
Proceedings. Arlington, Va., U.S. Public Health Service, 1967.

Cuba. Ministerio de Salubridad y Asistencia Social.
. . . Centenary of the graduation of Dr. Carlos J. Finlay in Jefferson Medical College. Havana, Ministerio, 1956.

Cudkowicz, Leon.
The human bronchial circulation in health and disease. Baltimore, Williams & Wilkins, 1968.

Current psychiatric therapies. v. 8, 1968.
New York, Grune & Stratton, 1968.

Davis, David A.
Historical vignettes of modern anesthesia. Philadelphia, F. A. Davis, 1968.

Durbin, Richard L.
Organization and administration of health care. St. Louis, Mosby, 1969.

Expanding concepts in mental retardation.
Springfield, Ill., Thomas, 1968.

Exploratory concepts in muscular dystrophy and related disorders.
New York, Excerpta Medica, 1967.

Feldman, Jacob J.
The dissemination of health information. Chicago, Aldine Pub. Co., 1966.

Fowler, Noble O.
Cardiac diagnosis. New York, Hoeber Medical Division, 1968.

Florida. State Board of Health.
St. Louis encephalitis in Florida. Jacksonville, Fla., Florida State Board of Health, 1969.

Fundamental problems in scanning.
Springfield, Ill., Thomas, 1968.

Glenn, James Francis.
Diagnostic urology. New York, Hoeber Medical Division, 1964.

Gould, Sylvester Emanuel.
Pathology of the heart and blood vessels. 3rd ed. Springfield, Ill., Thomas, 1968.

Guralnick, Walter C.
Textbook of oral surgery. Boston, Little, Brown, 1968.

Hall, Jacquelyn H.
Psychological and social aspects of human tissue transplantation. . . Washington, U.S. Public Health Service, 1968.

Hashimoto, Ken.
Appendage tumors of the skin. Springfield, Ill., Thomas, 1968.

Hollander, Mark B.
Ultrasoft X-rays. Baltimore, Williams & Wilkins, 1968.

Holt, George W.
The vagi in medicine and surgery. Springfield, Ill., Thomas, 1968.

Hough, Jack V. D.
Malformations and anatomical variations seen in the middle ear . . . Collinsville, Ill., Laryngoscope, 1958.

International directory of psychologists, exclusive of the U.S.A.
Assen, The Netherlands, Royal Vangorcum, 1966.

Institute on the Ministry to the Sick, 1st—
Cumberland, Maryland, Memorial Hospital, 1967.

International Symposium on Plastic and Reconstructive Surgery of the Eye and Adnexa. 2nd.
Proceedings. St. Louis, Mosby, 1967.

Joint Meeting of the Clinical Society and Commissioned Officers Association of the U.S. Public Health Service.
Proceedings. Washington, U.S.P.H.S., 1969.

Jones, Malcolm D.
Basic diagnostic radiology. St. Louis, Mosby, 1969.

Keith, Haddow M.
Convulsive disorders in children. Boston, Little, Brown,, 1963.

Kempe, Ludwig G.
Operative neurosurgery. New York, Springer-Verlag, 1968.

Lin-Fun, Jane S.
Hemolytic disease of the fetus and newborn due to RH isoimmunization. Washington, U.S. Children's Bureau, 1969.

A list of worthwhile life and health insurance books, 1968.
New York, 1968.

Loria, Frank L.
Historical aspects of abdominal injuries. Springfield, Ill., Thomas, 1968.

Marshall, John.
The management of cerebrovascular disease. 2nd ed. Boston, Little, Brown, 1968.

Maryland Medical Service, Inc.
Maryland Blue Shield manual for participating physicians. Baltimore, Maryland Medical Service, Inc., 1968.

Mayer, Jean.
Overweight. Englewood Cliffs, N.J., Prentice-Hall, 1968.

Mealy, John.
Pediatric head injuries. Springfield, Ill., Thomas, 1968.

Migraine Symposium, 1st, London, 1966.
Background to migraine. New York, Springer-Verlag, 1967.

Moss, William T.
Therapeutic radiology. 3rd ed. St. Louis, Mosby, 1969.

National Advisory Commission on Civil Disorders.
Supplemental studies for the National Advisory Commission on Civil Disorders. Washington, U.S. Government Printing Office, 1968.

National Advisory Neurological Disease and Blindness Council. Subcommittee on Vision and Its Disorders.
Vision and its disorders. Bethesda, U.S. Public Health Service, 1967.

National Conference for Professional Nurses and Physicians.
Proceedings. Chicago, AMA, 1967.

National Conference on Aging, First.
Man and his years. Raleigh, Health Publications Institute, Inc., 1951.

National Library of Medicine. Reference Services Division.
Medical research institutions named after medical men. Bethesda, National Library of Medicine, n.d.

National Tuberculosis Association.
The TB clinic. New York, National Tuberculosis Association, 1967.

National Working Conference on Health Aspects of Hearing Conservation.
Health Aspects of hearing conservation. Rochester, Minn., American Academy of Ophthalmology and Otolaryngology, 1959.

Naylor, Vera M.
The sufferings of the cancer patient. London, Hutchinson Benham, 1967.

New York Heart Association.
Nomenclature and criteria for diagnosis of diseases of the heart and blood vessels. 5th ed. New York, 1953.

Niehans, Paul.
The cancer problem. Berne, Stämpfli Cie Ltd., 1969.

Orr, Thomas Grover.
Operations of general surgery. 4th ed. Philadelphia, Saunders, 1968.

Pedersen, Jórgen.
The pregnant diabetic and her newborn. Baltimore, Williams & Wilkins, 1967.

Post-traumatic pulmonary insufficiency. . . by Francis D. Moore [and others].
Philadelphia, Saunders, 1969.

Prior, John Alan.
Physical diagnosis. St. Louis, Mosby, 1969.

Progress in Drug Research.
Pharmaceutical Manufacturers Association Research Symposium. Washington, Pharmaceutical Manufacturers Association, 1969.

Progress in medical genetics. V. 1-6.
New York, Grune & Stratton, 1961-1969.

Radbill, Samuel X.
A tour of the College of Physicians of Philadelphia. Baltimore, College of Physicians of Philadelphia, 1965.

Reisman, Leonard E.
Genetics and counseling in medical practice. St. Louis, Mosby, 1969.

Remmen, Edmund.
Psychochemotherapy, the physicians manual. Los Angelos, Western Medical Publications, 1962.

Roche handbook of differential diagnosis. [Variously titled].
Nutley, N.J., Roche Laboratories.

Salzman, Leon.
The obsessive personality. New York, Science House, 1968.

Saunders, William H.
Atlas of ear surgery. St. Louis, Mosby, 1968.

Schneewind, John H.
Medical & surgical emergencies. 2nd ed. Chicago, Year Book Medical Publishers, 1968.

Silverman, Charlotte.
The epidemiology of depression. Baltimore, Johns Hopkins Press, 1968.

Stevens, Audrey D.
America's pioneers in abdominal surgery. Melrose, Mass., American Society of Abdominal Surgeons, 1968.

Symposium on pulmonary disease, 8th Denver, 1955.
A lecture series held annually as a combined program of professional services. Denver, Fitzsimons Army Hospital, 1955.

Symposium on the Spine, Cleveland, 1967.
St. Louis, Mosby, 1969.

Toxicity bibliography, v. 1
Washington, National Library of Medicine, Jan. 1968.

U.S. Children's Bureau.
Services for crippled children. Washington, U.S. Department of Health, Education and Welfare, 1968.

U.S. Department of Housing and Urban Development.
HUD aids for financing medical practice facilities. Washington, HUD, 1967.

U.S. Food and Drug Administration.
Federal Food, Drug and Cosmetic Act, as amended. Washington, USPHS, 1969.

U.S. National Center for Chronic Disease Control.
From head to toe. Arlington, Va., U.S. Public Health Service, 1968.

U.S. National Communicable Disease Center.
Syphilis, a synopsis. Atlanta, U.S. Public Health Service, 1967.

U.S. National Communicable Disease Center.
Tuberculosis program reports. Atlanta, U.S. Public Health Service, 1967.

U.S. National Heart Institute.
Hypertension. Bethesda, National Institutes of Health, 1969.

U.S. National Institute of Allergy and Infectious Diseases.
Catalog of research reagents. Bethesda, National Institutes of Health, 1968.

U.S. 91st Congress, 1st session, 1969. House.
Letter from the Secretary of Health Education and Welfare on the Medicare Program. Washington, U.S. Government Printing Office, 1969.

U.S. Public Health Service. Health Services and Mental Health Administration.
Public Health service-labor seminar on consumer health services. Washington, USPHS, 1968.

U.S. Public Health Service. Division of Chronic Disease Programs. Diabetes and Arthritis Control Program.
Diabetes control. Arlington, Va., USPHS, 1969.

U.S. Public Health Service. Division of Health Care Services.
Guidelines for development of comprehensive health services projects . . . Washington, U.S. Public Health Service, 1969.

U.S. Public Health Service. Division of Regional Medical Programs.
Regional Medical programs and their relationships to the urban community and the poor. Washington, U.S. Government Printing Office, 1968.

Walsh, Robert E.
Your community hospital. Boston, Beacon Press, 1969.

War injuries of the abdomen.
Summit, N.J., Ciba Pharmaceutical Products, 1945. [10 color plates]

Watson, Andrew S.
Psychiatry for lawyers. New York, International Universities Press, 1968.

Williams, Richard Hays.
Processes of aging. New York, Atherton Press, 1963.

Winter, Chester C.
Practical urology. St. Louis, Mosby, 1969.

Zirkle, Thomas E.
A comprehensive guide to corporate practice. Evanston, Ill., Harbrace Publications, 1969.

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

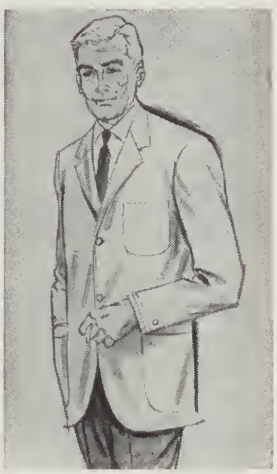
#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#801—65 Poly./35 cot. Tricot **$6.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only

Sizes 34 to 46





MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab **$9.99**

Sizes 28-40

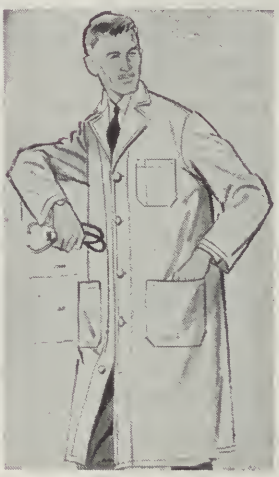
- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$8.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46



OTHER STORES IN →

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.
Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.
Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia. In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.
Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.
Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").
Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**

(potassium phenoxymethyl penicillin) Wyeth®

The High Cost of "Driver Error"

Automobile accidents in 1968 injured more than 4,400,000 persons on America's highways. Driver error, according to The Travelers Insurance Companies annual statistics, was responsible for more than 80% of last year's highway casualties.

Do Your Patients Need Nursing Service?

Call **889-5666**

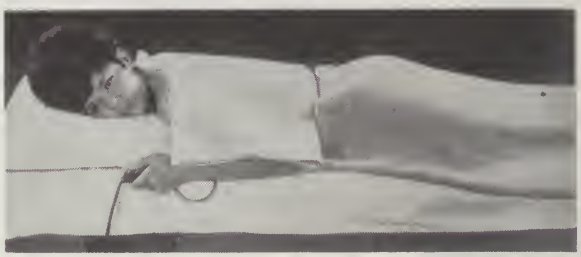
COBB-WOODS SERVICES

Vera Woods, M. A. Director

2213 St. Paul St. Baltimore, Md. 21218

Licensed by the State of Md.

Now When You Recommend Moist Heat,



Recommend Automatic Moist Heat.

Until now, application of moist heat required boiling water, hot towels, and somebody to apply them. The Battle Creek THERMOPHORE changes all that. It provides instant and automatic moist heat, intensely hot, deeply penetrating.

The patient simply plugs it into an outlet. This unique hot fomentation pad then generates its own moisture from the air. Intensely hot moist heat is constantly maintained, and evenly distributed throughout the pad. No water is needed, no filling or emptying is required.

Large 13" x 27" pad covers back, or chest and abdomen, or both legs. Safety thermostat turns it off automatically, prevents overheating.

Price is **$35.00.** Also available in medium size 13 x 13 **$25.00.**

Phone for Free Descriptive Literature, or See It At . .

THERAPEUTIC APPLIANCES, INC.

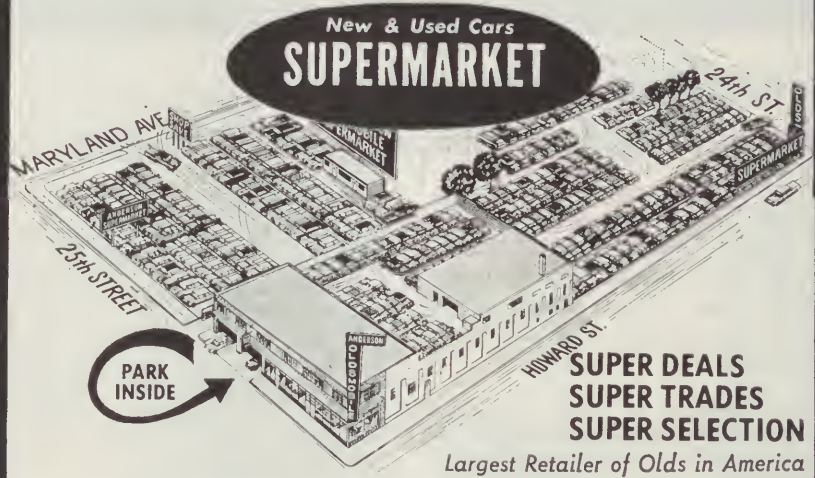
JULES MORSTEIN

1114 Light St. Phone 752-6996

Baltimore, Md. 21230

ESCAPE FROM THE ORDINARY IN A NEW

1970 OLDS



SUPER DEALS
SUPER TRADES
SUPER SELECTION

Largest Retailer of Olds in America

FOR 50 YEARS A NAME YOU CAN TRUST

A. D. ANDERSON OLDSMOBILE

HOWARD & 25th STS. – HO 7-8800

Developing Meaningful Mental Health Statistics

KURT GORWITZ, ScD
Statistics Director
Maryland State Department of Mental Hygiene

In 1841, Dr. William Farr published in the JOURNAL OF THE BRITISH STATISTICAL SOCIETY a paper entitled "The Mortality of Lunatics". Farr, a prolific and cogent writer who served for many years as Superintendent of the Statistical Department of England's Registrar General's office, is recognized as one of the pioneers in health statistics. His paper, based on a life-table technique, showed a clarity of language, an understanding of the subject matter, and a sophistication of analysis equalled only infrequently since that time.

With rare and notable exceptions, the field of mental health statistics today consists of a type of repetitive clerical bookkeeping limited to monitoring the flow of patients into, and out of, publicly operated mental hospitals. That is, data are generally collected and released for administrative purposes as a tool in the management of an agency's operations. The limitations of these statistics, together with their drab and dull manner of presentation, not only severely hinder potential research value and interest, but also conflict with communication between statisticians and other professional personnel.

As part of my doctoral dissertation in 1965,[1] I studied biostatistics programs in Canadian and United States schools of public health and surveyed operations of mental health statistics offices in each of the 50 U.S. states. An analysis of data through 1967 from public health schools is now in press.[2] I also conducted a survey of state mental health programs in 1967 and detailed findings will be released shortly.[3] In this latter survey, a majority, 28 of the 48 respondents, reported that during the preceding three years their staff had neither presented any papers at professional meetings nor published any papers in professional journals. The number of employees was small (a median of five) and most classified as clerical. Directors and others on their staffs rarely had undergraduate or graduate degrees in statistics. The average cost of maintaining these programs was less than $50,000 per year, or approximately 0.2% of total budgets for mental health services. Only 16 states collected data in one central office on patients in private psychiatric hospitals and outpatient psychiatric centers, in addition to public mental hospitals. The over-all impression was that the capability for measuring and evaluating current and new concepts and programs for the treatment of the mentally ill was largely nonexistent.

Reproduced from Canada's Mental Health, Bi-Monthly Journal of the Department of National Health and Welfare, Ottawa. Vol. XVII, No. 3, pp. 13-17. May-August 1969.

Current Deficiencies

A number of factors are responsible for these deficiencies. It is my distinct impression that one of the most important is the widespread lack of interest in, understanding of, and encouragement for statistical research on the part of mental health program directors. The noticeable absence of efforts to raise the level of statistical services indicates, I believe, that most administrators consider current programs to be acceptable and adequate. This, in turn, reflects the traditional position of many mental health program directors that their responsibility is limited to the administration of public facilities rather than to the broader role of supervising, directing and co-ordinating all programs related to mental health. Interrelated with this is the failure of those employed as statisticians to assume the initiative in developing more meaningful programs, in expanding research services and in presenting data in a professional and understandable manner. For example, although data based on the unduplicated count of individuals served in a given set of facilities during stated time periods are basic and relatively simple to obtain—even without the use of computers—such statistics are in fact virtually nonexistent. Rather, most reports are limited to counting treatment episodes instead of persons treated. This lack of sophistication, in turn, reflects deficiencies in training programs for statisticians, particularly in schools of public health.

The statistical field is caught up in a circle the various segments of which link to produce low level programs of dubious value. Educational institutions emphasize theoretical instead of applied statistics; in general, they fail to relate this knowledge to specific subject matter; and finally, they do not offer field

training. As a result, a minority of graduates, particularly those with advanced degrees, work in public health agencies. It should not be surprising, therefore, that the educational background of most persons designated as biostatisticians is in other areas, and that their experience in the mental health field is limited. Further, low salaries, limited levels of responsibility, and the repetitive clerical nature of their work have produced high employee turnover rates and low-quality staff. And this has been perpetuated by the failure of mental health program directors to seek better statistical services and to take the necessary corrective steps.

It is most important that the facts be clearly recognized and understood, and that basic decisions be reached as to whether or not existing program levels are acceptable. If they are not, as I firmly believe, a number of remedial actions are essential. In order for the circle to be broken, the impetus for change must come primarily from those now employed as mental health statisticians. Miss Brooke, in her article "Do Psychiatric Administrators Need Statisticians?", has detailed succinctly some of the steps necessary for producing meaningful mental health statistics. It is my belief that these efforts can be categorized into four broad areas:

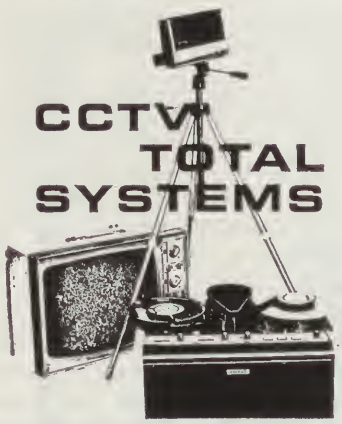
1. Data must be based on uniform, centralized reporting from all inpatient and outpatient, both public and private psychiatric facilities, in order to measure the total extent of services.

2. Procedures must be established for unduplicating data in order to study cohorts of individuals over time; to analyze patterns and sequence of service utilization; and to evaluate the efficacy of various treatment modalities.

3. Data must be related to available population statistics for the computation of rates and determination of longitudinal trends.

4. Findings must be presented in a clear, concise and meaningful manner and should be distributed, or available, to all interested agencies and individuals. Wherever possible, associates in related fields (ie, psychiatry, psychology and sociology) should participate in special studies and in the analysis and interpretation of statistical data.

Biostatisticians have limited staff and time, and are notoriously overburdened with routine, repetitive work. It is essential that these responsibilities be re-evaluated and re-examined in order to eliminate needless effort and provide maximum time for more appropriate projects. Our experience has been that the goals referred to above are attainable. Maryland is in the process of achieving these objectives and, possibly, could serve as a model for other areas seek-


CCTV TOTAL SYSTEMS
PLANNING, ENGINEERING, INSTALLATION & SERVICE
We Feature AMPEX
VIDEOTAPE RECORDING EQUIPMENT
Call Today for a Free Demonstration
high fidelity house
6307 YORK ROAD (Drumcastle) BALTIMORE, MD.
Phone 323-3713

• ART SERVICES
• COMPOSITION
• OFFSET & LETTERPRESS
• ROTARY
• FLEXOGRAPHIC
• PAMPHLET & BOOKBINDING
• MAILING
THE EVANGELICAL PRESS
THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411
"Making Good Impressions Through Good Impressions"

ing to develop more meaningful mental health statistics.

The Maryland Department of Mental Hygiene, in co-operation with the National Institute of Mental Health, established a research program in July, 1961, known as the Maryland Psychiatric Case Register.[4] This project is based on routine, uniform reporting of data from more than 150 psychiatric facilities which provide almost 100% of such services to residents of the State. Confidentiality of individual patient information is assured by a state statute adopted in 1963. In the nearly eight years of its existence, more than 100,000 Marylanders (or 3% of the total population) have been identified as receiving psychiatric care. Currently, approximately 40,000 admissions of 30,000 individuals are reported annually to the Register. Of these, 10,000 are not known to have received previous care. Computerized techniques for maintaining and updating Register records have been developed and output has been primarily in four major areas; data used internally by the Department for the planning and evaluation of psychiatric services; routine reports, including a monthly statistics newsletter, which deals with a variety of mental topics (this newsletter is also published monthly in the state medical journal); a series of papers based on research findings presented at professional meetings and published in various professional journals—others are now in preparation; and finally, data used for research and management by staff of the participating facilities and by faculty members and students at The Johns Hopkins University School of Hygiene and Public Health and at The Johns Hopkins and University of Maryland Schools of Medicine.

Upgrading the Statisticians

It should be clear, however, that efforts by those presently employed as mental health statisticians to upgrade their programs can be only of limited value unless other corrective steps are also taken. Some of these, noted in random fashion, include:

1. Mental health program directors must consider statistics to be an integral, key part of their administrative and research structure. As such, statisticians should be expected to participate in and contribute to management decision-making and should also be expected to work with other researchers.

2. Salaries must be increased substantially in order to attract and retain competent personnel. Concomitantly, job requirements should be raised and the size of the statistical staff expanded. Provisions should be made for leave of absence, with pay and tuition reimbursement. for graduate or postgraduate study. Intra and inter-agency on-the-job training programs in statistics should be developed.

(Continued next page)

The Robert Morris Inn — 1710
ON THE SCENIC TRED AVON RIVER, OXFORD, MD.



Dinner—5:30 to 10 P.M. Lunch—11:30 A.M. to 2:30 P.M. Sunday Dinner—1:30 to 9 P.M.

Duck and Goose Season—October 31 thru January 15. The most complete hunting package on the Eastern Shore.

DINING ROOM
TAP ROOM
TAVERN
PACKAGE LIQUOR
ROOMS

Visit Us Soon

OXFORD,
MARYLAND
CA 6-5111

T. ROWE PRICE
GROWTH STOCK
FUND, INC.
BALTIMORE, MARYLAND

A stock portfolio carefully selected
for possible growth of principal and income.

NO SALES CHARGE
NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

3. Administrators and professionals must be more knowledgeable in statistics. Therefore, curricula in the mental health professions should include required courses in applied statistics.

4. Schools of public health must put greater emphasis on applying statistics to health data. Health statisticians should be used as instructors, and mental health and other health data should be used for dissertations and other class projects. Field training should be mandatory for all students. Wherever possible, joint courses should be given by mental health and biostatistics departments.

The circumstances and conditions for developing comprehensive statistical programs are not likely to be as favorable elsewhere as they have been in Maryland. Our Register program, for example, has received a great deal of financial and technical support from the National Institute of Mental Health. Thus, while it may not be feasible at this time for many other states or Canadian provinces to develop data banks as comprehensive as those in Maryland, much could be done on a more limited scale by creative statisticians and with the present available means—if significant support were given. The experience gained in Maryland from our program could be helpful to others in these endeavors.

REFERENCES

1. A Critique of Past and Present Mental Health Statistics in the United States and A Blueprint for Future Program Development. Johns Hopkins University School of Hygiene and Public Health, 1966.
2. Programs in Biostatistics at the Master's and Doctoral Level. Accepted for publication by *Public Health Reports.*
3. Mental Health Statistics on the State Level. (unpublished)
4. Gorwitz, Kurt: U. S. Mental Hospital Trends, *Can's. Ment. H'lth.* (July '65) p. 20.

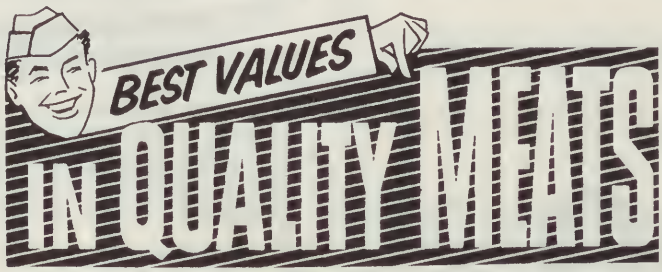


Give your home new beauty with
SKILLFUL LANDSCAPING
TREES, PLANTS, SHRUBBERY
expertly planned and planted
FREE ESTIMATES
BELTWAY GARDEN CENTER
7937 Belair Road, Baltimore Md. 21236 NO 8-3965

COLOSTOMY
ILEOSTOMY
Appliances and Disposable Bags
CALL
FIELDS PHARMACY
IN PIKESVILLE
for convalescent supplies and service
FOR RAPID DELIVERY 486-3300

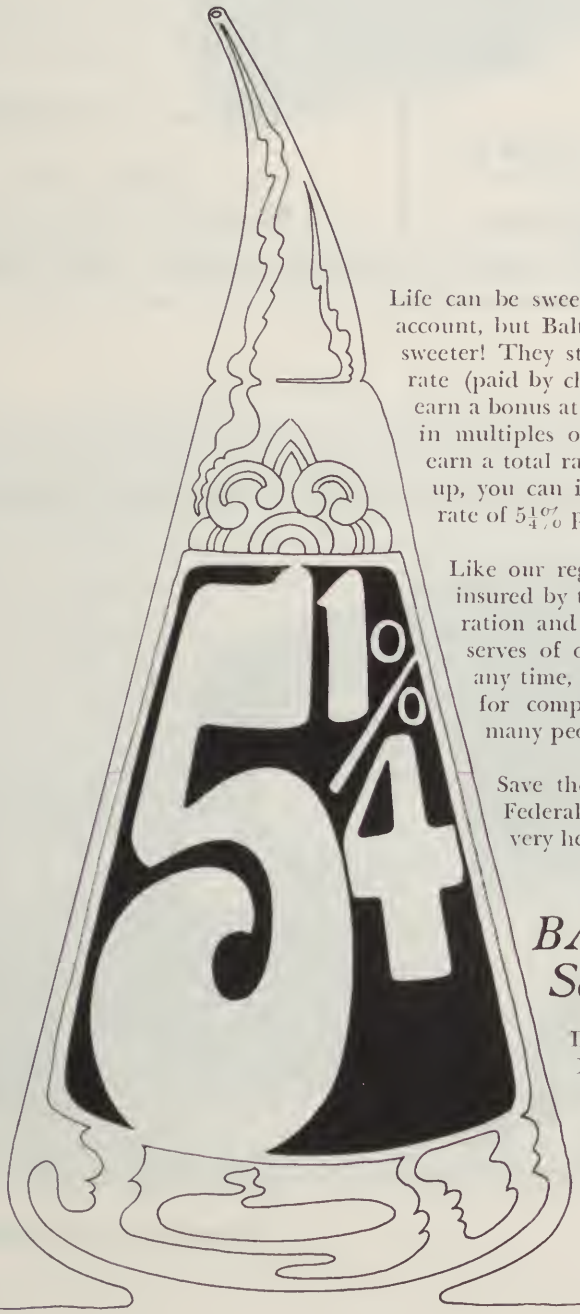
WHEN YOUR PATIENTS NEED NURSING CARE
Call Milton 4-6060

Alice Weber
Baltimore Nurses Exchange
LICENSED & BONDED
24 HOUR SERVICE ESTABLISHED 1935
BALTIMORE, MARYLAND 21229

COUNTRY MEATS
FOR BEST IN BEEF
U.S.D.A. CHOICE
U.S.D.A. PRIME


TAKE RT. 40 WEST TO ST. JOHN'S LANE, TURN LEFT 1 BLOCK TO COUNTRY MEATS
ELLICOTT CITY, MD. HO 5-5233

THE SWEETENER



Life can be sweet when you have a Baltimore Federal savings account, but Baltimore Federal Savings Certificates can be even sweeter! They start by earning interest at our current interest rate (paid by check at regular quarterly interest periods), then earn a bonus at maturity. You can invest from $1,000 to $11,000 in multiples of $1,000 for either six months or a year and earn a total rate of 5% per annum guaranteed! From $12,000 up, you can invest for either period and earn a guaranteed rate of 5¼% per annum.

Like our regular passbook savings account, your money is insured by the Federal Savings and Loan Insurance Corporation and further backed by Baltimore Federal's own reserves of over $25,000,000. Certificates may be cashed at any time, earning interest at our regular rates. Of course, for complete flexibility combined with high interest, many people still prefer our passbook accounts.

Save the way it suits you best . . . any of Baltimore Federal's five plans sweetens your savings with some very heavy sugar.

BALTIMORE FEDERAL
Savings & Loan Association

Downtown at Fayette and St. Paul Streets • Eastpoint Shopping Center • Reisterstown Road Plaza • Towson at 7 Alleghany Ave. • Carney at 9609 Harford Road • Yorktowne Plaza Shopping Center • Columbia, Teachers Building • Westminster at 6 E. Main Street.



Danny's

formal wear

Specializing in fine formal clothing

RENTED and SOLD

6218 Reisterstown Rd.
(2 blks. South of Reisterstown Plaza)

FLeetwood 8-1142
Baltimore, Md. 21215

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

HARRIS CREEK WATERFRONT



Early American architecture . . . 12 acres for complete seclusion . . . protected anchorage . . . private tree-lined driveway . . . beautifully landscaped grounds with fruit trees, magnolias, evergreens

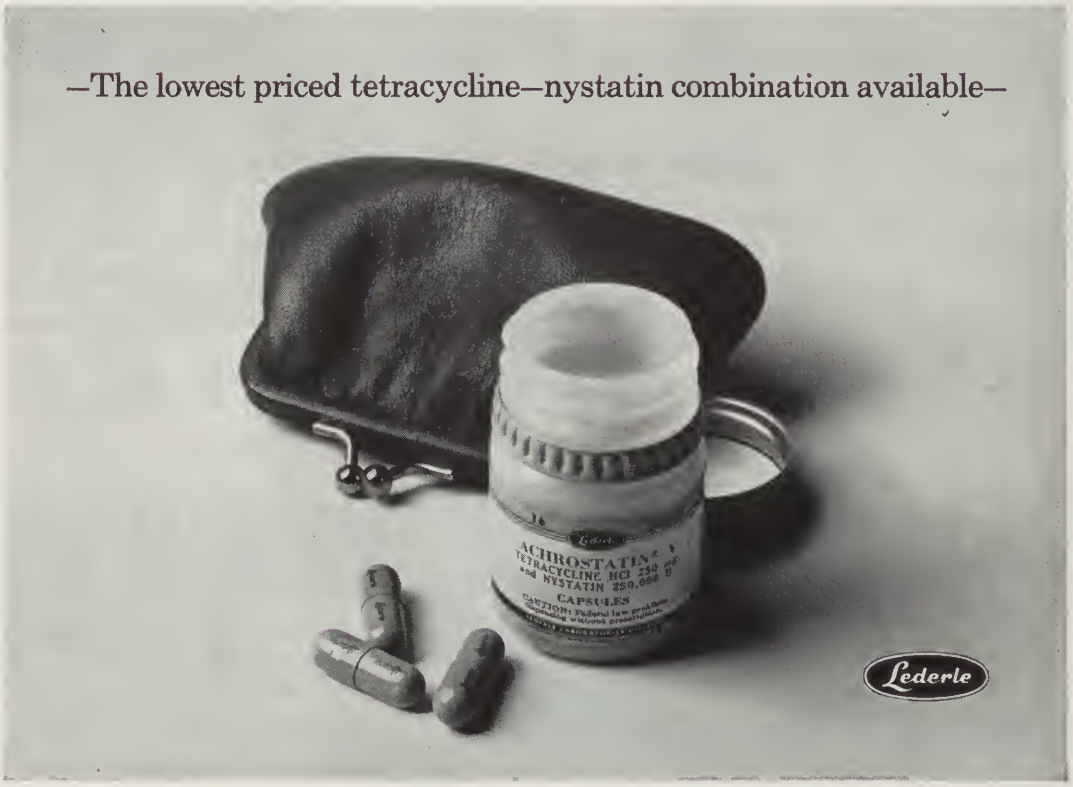
Offered at $65,000

For details, contact

HELAINE WHITE, *Realtor*

Easton, Maryland (301) 822-4626

—The lowest priced tetracycline—nystatin combination available—



HINDER'S Proudly Presents

The 1970 LINCOLN *Continental*

AMERICA'S MOST DISTINGUISHED MOTORCAR



Unrivalled leader of the luxury parade for 1970—the Lincoln Continental. Engineered to be the best automobile America has to offer. . . . Built to the world's highest standards. And because it is designed with a style that is beautiful, the Continental is a sound and lasting investment. Come see how you can live the Continental life.

See all the Ford Family of Fine Cars

CONTINENTAL
MERCURY
COUGAR
MONTEGO
COMET

FORD
MUSTANG
THUNDERBIRD
FALCON
FAIRLANE

FORD TRUCKS

317 S. Philadelphia Blvd.
Aberdeen, Maryland
Phone
272-4300

Baltimore
Telephone
575-6925

505 S. Philadelphia Blvd.
Aberdeen, Maryland
Phone
272-2200

HINDER MOTORS, INC.

ABERDEEN, MD. 21001

Also Daily Rental Units and Long-term Lease Cars

The Secret of Longevity

Beer is a health drink. If you drink one bottle every day for 1,200 months, you'll live to be a hundred years old.

STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

We Repair and make Lamps
"Lamps make the home Beautiful"

LE 9-0222 403 N. Charles Street
Baltimore, Md. 21201

A & F Nurses Registry



LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

Registered & Licensed

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St. BElmont 5-7135
613 Homestead St. If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

Baltimore's most unusual dining place!

Famous **Owl Room**



Belvedere Hotel
Charles & Chase Streets

Watch Future Issues For:

- More information on Med-Chi's 172nd Annual Meeting
- A Special Issue on Traffic Safety
- A Medical-Legal Debate

NOW
A NEW CONCEPT
in
BOOKEEPING
and
TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

SECURITY BUSINESS SERVICES, INC.

Box 335
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager

Two-Year Medical Assistant Curriculum Approved

Essentials of an accredited educational program for medical assistants received unanimous approval of the American Medical Association's House of Delegates at its July meeting in New York. This achievement marks the beginning of approved schools in medical assisting.

Established by the AMA's Council on Medical Education in collaboration with the American Association of Medical Assistants, the essentials will serve as a guide for the development of effective educational programs for medical assistants.

The essentials recommend that the two-year program be broad in scope, "providing a basic understanding of medicine, some acquaintance with clinical work, familiarity with medical ethics and law, and a comprehensive knowledge of how to operate a doctor's office efficiently and successfully." It suggests that the training should aim at developing adeptness in promoting good relations with patients and the public at large, and a capability for calm and reasoned judgments in meeting emergencies.

The basic curriculum is based on the AAMA certification study outline. Topics include anatomy and physiology; medical terminology; medical law, ethics, and economics; psychology; administrative and clinical procedures; and a basic knowledge of the purpose and technique of laboratory procedures commonly performed in the physician's office. A review and rotation sequence of practical experience in offices of qualified physicians or in accredited hospitals selected by the educational institution is also recommended.

While it will be several months before the AMA-AAMA team begins to evaluate schools, applications are being accepted by the AMA's Department of Allied Medical Professions and Services.



The MEDICAL and CHIRURGICAL FACULTY of the State of Maryland

ACCIDENT AND HEALTH PROGRAM FOR FACULTY MEMBERS

- ACCIDENT AND SICKNESS TOTAL DISABILITY
- MAJOR MEDICAL EXPENSE
- ACCIDENTAL DEATH AND DISMEMBERMENT

Administered by
THE MED-CHI INSURANCE TRUST

Official Faculty Agent
B. Dixon Evander and Associates

Underwritten by
Hartford Accident and Indemnity Company

Member of
The Hartford Insurance Group
Hartford, Connecticut

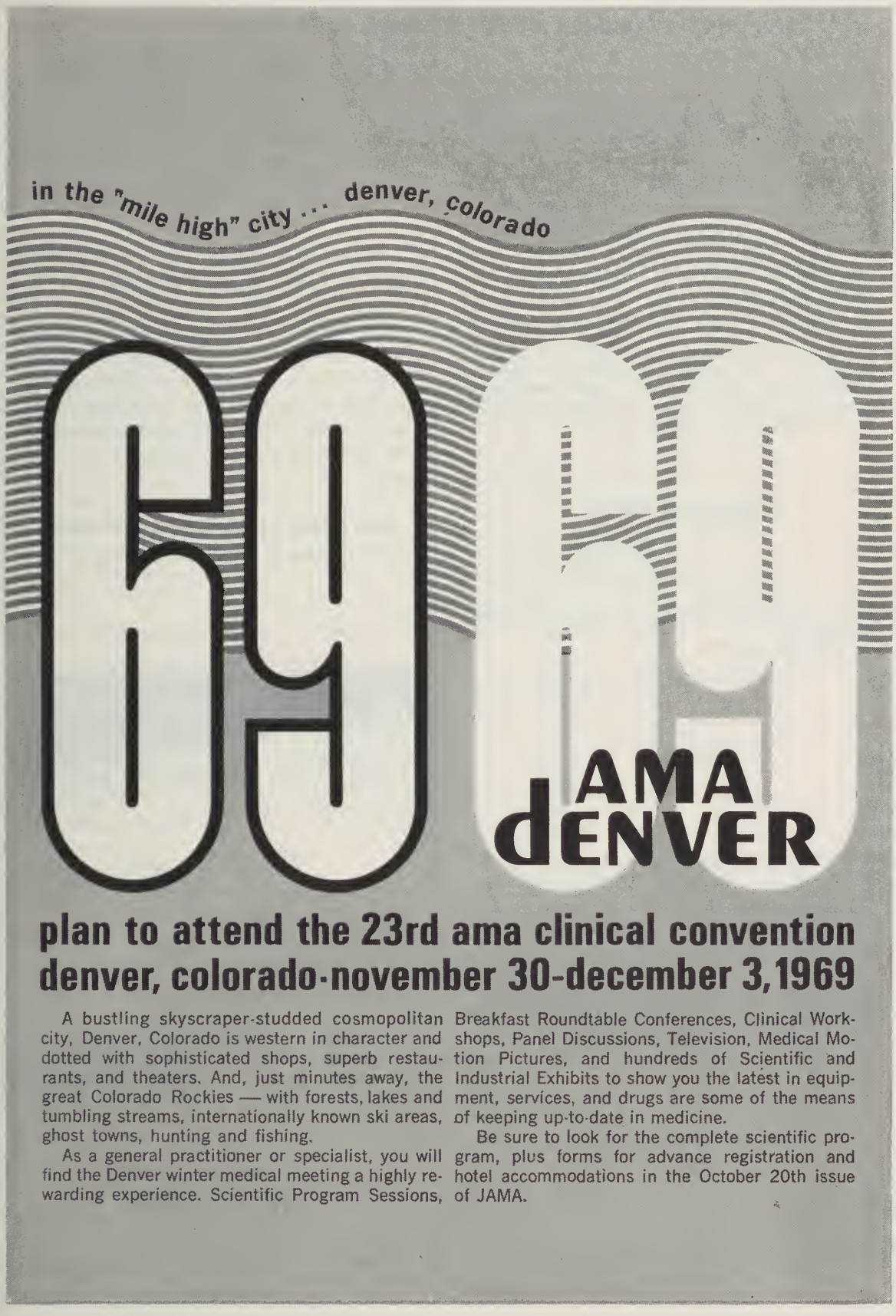
For more information detach and mail slip directly to:

MED-CHI INSURANCE TRUST
1211 Cathedral Street, Baltimore, Maryland 21201

*Name*_____

*Address*_____

*City and State*_____ *Zip Code*_____



plan to attend the 23rd ama clinical convention denver, colorado·november 30-december 3,1969

A bustling skyscraper-studded cosmopolitan city, Denver, Colorado is western in character and dotted with sophisticated shops, superb restaurants, and theaters. And, just minutes away, the great Colorado Rockies — with forests, lakes and tumbling streams, internationally known ski areas, ghost towns, hunting and fishing.

As a general practitioner or specialist, you will find the Denver winter medical meeting a highly rewarding experience. Scientific Program Sessions, Breakfast Roundtable Conferences, Clinical Workshops, Panel Discussions, Television, Medical Motion Pictures, and hundreds of Scientific and Industrial Exhibits to show you the latest in equipment, services, and drugs are some of the means of keeping up-to-date in medicine.

Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 20th issue of JAMA.

Classified Advertising

POSITIONS AVAILABLE

GENERAL SURGEON—For 1150-bed Psychiatric Hospital with 150 beds active General Medical Service and 15 Surgical beds. Research facilities available. Primary responsibility: diagnosis, consultation, and emergency procedures. All major surgical procedures performed at another VA hospital. Salary $18,531-$28,069 depending upon qualifications. Upper Chesapeake Bay area, station housing at reasonable rental, golfing, fishing, and boating facilities available. Contact: Chief of Staff, Veterans Administration Hospital, Perry Point, Md. 21902. Tele. No. (301) 642-2411, ext. 253. An Equal Employment Opportunity Employer.

GP PARTNERSHIP—Percentage of salary. Retiring in 2-3 years. Two-man office. Not doing hospital work, but open staff hospitals available. Good country. Congenial people. Professional and personal data requested. Send reply to: Box #9, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

POSITION WANTED

STAFF PSYCHIATRIST—Will have Md. reciprocity license in 1970. Please contact: Peter T. Han, MD, VA Hospital, Brooklyn, N.Y. 11209, (212-TE 6-6600, ext. 258).

FOR RENT

THREE-ROOM SUITE—Suitable for GP or other. 1st floor, private entrance. Located in private home of finished masonry block. Suite is 12 x 60' L-shaped. Waiting room, consultation room, 2 baths. Air-conditioned. Accessible to hospitals. Owner renting. Negotiable. Call: 889-8327 (Balto.).

PHYSICIAN'S OFFICE—In Pikesville. With or without furniture, equipment, and patients' records. Ample parking. Office is suitable for any practice. Call: 486-3872 anytime.

SERVICE OFFERED

MEDICAL ABSTRACTING—From Microfilm. Research, technical writing, no typing. Call: (301) 433-7965, Mrs. Manley.

CLASSIFIED ADVERTISING

Effective September 1, 1969

$2.00 per line per insertion

Count seven average words to each line. Add one line if box number is desired.

Members of the Medical and Chirurgical Faculty shall be entitled to one complimentary insertion in any twelve-month period. Widows of members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment.

MARYLAND STATE MEDICAL JOURNAL
1211 Cathedral St., Baltimore, Md. 21201



BOLTON HILL *Dinner Theatre*

"The Public Eye"
And
"Black Comedy"
Sept. 23 — Oct. 19

"The Crack of Doom"
Oct. 21 — Nov. 16

Dinner — 7 P.M.
Performance — 8:30 P.M.
FREE PARKING
CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
5 PM — 2 AM

for Reservations
call 728-0800

Baltimores Only Professional Dinner Theatre

Advertisers in This Issue

A & F Nurses Registry 130
Aids for Hearing, Inc. 76
Alcazar, The 96
American National Bldg. & Loan Assoc. 26
A. D. Anderson Oldsmobile, Inc. 122
Arch Laboratories 109
Arundel Federal Savings & Loan Assoc. 106
Baltimore Federal Savings & Loan Assoc. 127
Baltimore Nurses Exchange, Alice Weber 126
Baltimore Oxygen Supply Co., Inc. 96
Belvedere Hotel 130
Bolton Hill Dinner Theatre 134
Bridgeforth's Junior Bootery 76
Bristol Laboratories 44
Broadview Restaurant 93
Burroughs-Wellcome & Co. 97
Campbell Soup Company 41
Capital Savings & Loan Assoc. 128
Oscar Caplan & Sons 8
Chesapeake Farm, Inc. 74
Club Venus 93
Cobb-Woods Services 122
Cork 'n Bottle Restaurant 93
Country Meats 126
Danny's Formal Wear 128
Doctor's Supply Co. 27
Edgewood Nursing Home ..... Cover 2
Eleven East Chase St. Corporation 106
Emersonian Apt. Bldg. 96
The Evangelical Press 124
Fedder's Medical Services, Inc. 8
Field's Pharmacy 126
Franklin Uniform Co. 120
Geigy Pharmaceuticals 84-85, 90-91
Glenbrook Laboratories 7
The Hecht Co. Northwood Rooftop Restaurant .. 93
High Fidelity House 124
Highland Hospital 112
Hilton Nursing Home ..... Cover 3
Hinder Motors, Inc. 129
House in the Pines Nursing Homes 30
Hynson, Westcott & Dunning, Inc. 1
Key Circle Hospice 83
Lederle Laboratories 2, 26, 128
Eli Lilly & Co. 4
Lucas Brothers, Inc. 104
Maico Hearing Aids, Inc. 14
Maria's 300 Restaurant 93
Maryland Blue Shield 94
Maryland Psychiatric Research Center 109
Medical Personnel Pool 76
Mercantile-Safe Deposit & Trust Co. 32
Merck Sharp & Dohme 18-20
Metropolitan Wash. Blood Banks, Inc. 104
Michaelson Motors, Inc. 96
Miller Brothers Restaurant 93
Milton Inn 93
F. O. Mitchell & Bro., Inc. 96
Monarch Lincoln Mercury 112
The Robert Morris Inn 125
Murray-Baumgartner Surg. Instr. Co., Inc. 11
National Drug Co. 15-16, 28
Ocean City Convention Hall 76
Olney Inn 31
Palmer House Restaurant 93
Parke, Davis & Co. 80
Peabody Conservatory 106
Chas. Pfizer & Co., Inc., Pfizer Laboratories Division, Terramycin 24-25
Pielke Landscape Services 126
Wm. P. Poythress & Co., Inc. 100
T. Rowe Price Growth Stock Fund, Inc. 125
Professional Management Co. 11
Professional Systems & Services 17
Geo. Radebaugh & Sons 27
Read's Drug Stores 14
A. H. Robins Co. 12, 46-47
Roche Laboratories ..... 78-79, 98-99 Cover 4
Russell, Marsh & Kennedy, Inc. 82
Sandoz Pharmaceuticals 77
Manuel Schwartz Hearing Rehab. 88
G. D. Searle & Co. 42-43
Security Business Services, Inc. 131
Security Savings & Loan 14
Skill Surgical, Inc. 104
Smith, Kline & French Laboratories 86
Special Diet Shop 102
State-Sun Federal Sav. & Loan Assoc. 112
Sterling Lighting Co. 130
Strasenburgh Laboratories 21
Stuart 13
Mano Swartz—Furs 8
Therapeutic Appliances, Inc. 122
Tijuana Tacos 93
Tower Ford, Inc. 108
Towson Telephone Secretaries 88
Van Dyke & Bacon 14
D. Stuart Webb Advertising Services, Inc. 104
Westview Lounge & Supper Club 93
Helaine White, Realtor 128
White Rice Inn 93
Wyeth Laboratories 22-23, 110-111, 121
Zimmermann's Shoes 8

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number. the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

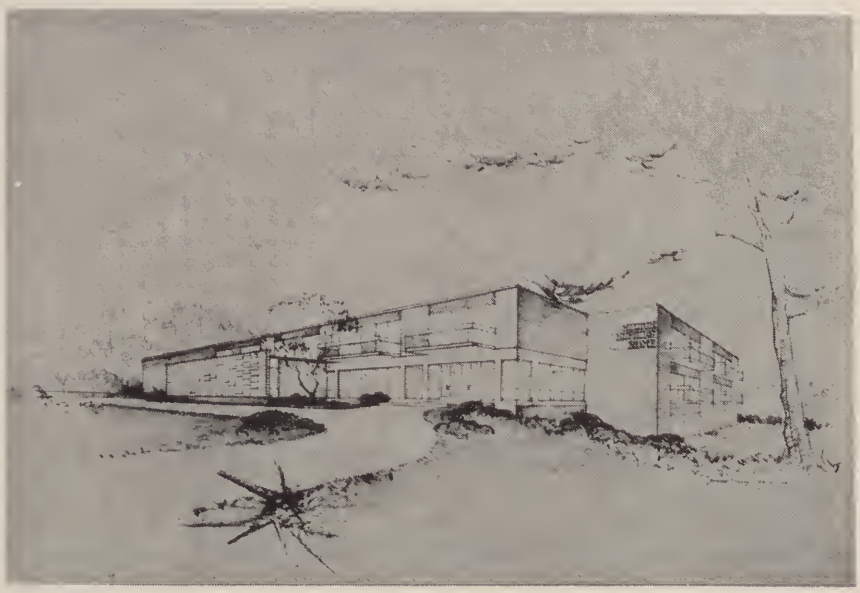
EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.

Open Fall 1969



The Gould Convalesarium — HILTON

3313 Poplar Street, corner of Hilton

4 blocks south of North Ave. & Hilton St.

BALTIMORE

Now completed—a superb new 100-bed facility, the last word in pleasant living and competent care for the aged, ill or convalescent. Embodying the highest standards and the most advanced equipment and luxurious furnishings, it will meet your most exacting requirements.

Modern, air-conditioned and fire-safe building

Finest facilities for comfort and health care

100 beds, all in private and semi-private rooms—
no wards or dormitories

Registered nurses 24 hours a day

Phone 426-3104 *or* 566-1300



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcitec states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

W1
MA791
K

MARYLAND

STATE MEDICAL JOURNAL
VOLUME 18 NUMBER 11
NOVEMBER 1969

READING

RECEIVED
DEC 1 8 1969
National Library
of Medicine



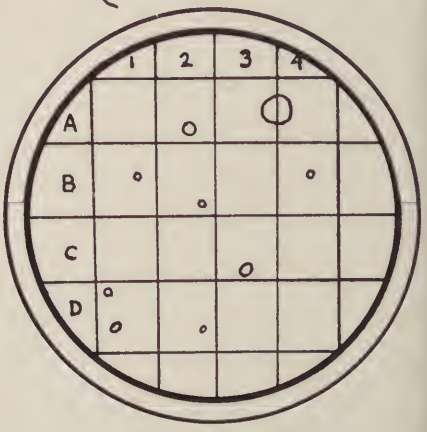
BETHESDA MD 20014

NOS·O·CO·MI·AL

ORIGINATING OR TAKING PLACE IN A HOSPITAL (~INFECTION)

Webster's Third New International Dictionary





HUNTINGDON RESEARCH CENTER, INC., offers an extensive bacteriological environmental monitoring service. A balanced program including surface and air sampling, device testing and sterilizer monitoring can be designed for every hospital budget. Monthly reports will stimulate cooperative action by medical, nursing and administrative staff.

For complete details call or write:

HUNTINGDON RESEARCH CENTER, INC.

Subsidiary of Becton, Dickinson & Co. (B-D)
Box 6857, Baltimore, Md. 21204 (301-825-3484)

LACTINEX®

TABLETS & GRANULES

■ **to help restore and stabilize the intestinal flora**

■ **for fever blisters and canker sores of herpetic origin**

Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.[1,2,3,4,5,6,7,8]

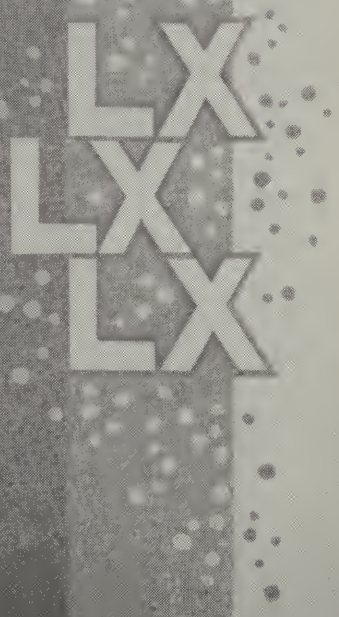
No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

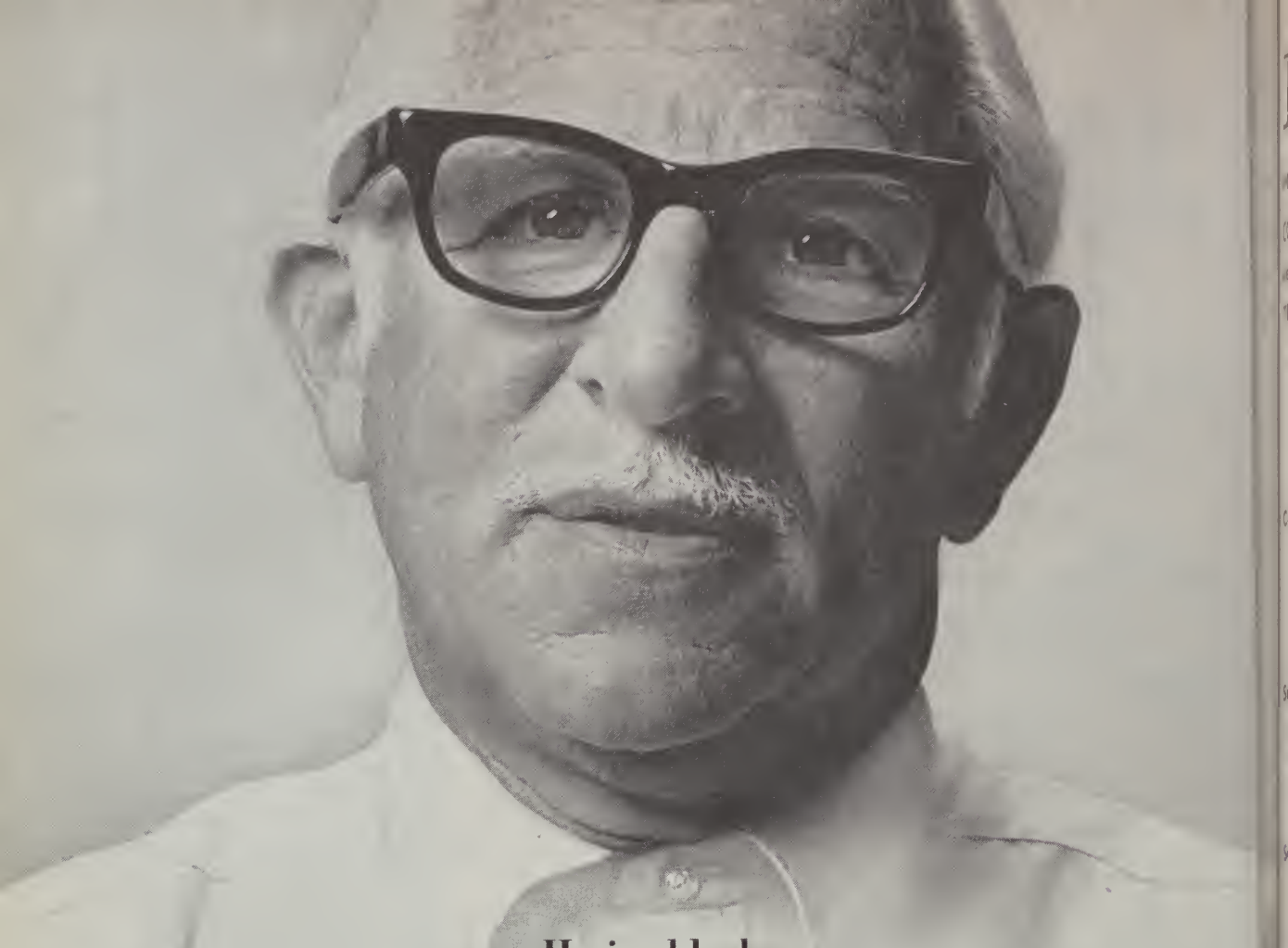
HYNSON, WESTCOTT & DUNNING, INC.

Baltimore, Maryland 21201

(LX-05)



References:
(1) Siver, R. H.: CMD, *21*:109, September 1954. (2) Frykman, H. H.: Minn. Med., *38*:9-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., *51*:16-18, January 19. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., *15*:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., *58*:2672-2673, August 1958. (6) Weekes, D.: EENT Digest, *25*:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., An., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Or Surg., Oral Med. & Oral Path., *20*:591-593, November 1965.



He is elderly.
He is on corticosteroids.
When he needs an antibiotic
he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN—the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Di stant observation is essential. If new infections appear, appropri measures should be taken. In infants, increased intracranial pres with bulging fontanels has been observed. All signs and symptoms w disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, a rhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculop ular and erythematous rashes; a rare case of exfoliative dermatitis been reported. Photosensitivity; onycholysis and discoloration of nails (rare). Kidney—rise in BUN, apparently dose related. Transi increase in urinary output, sometimes accompanied by thirst (re Hypersensitivity reactions—urticaria, angioneurotic edema, anaphyl Teeth—dental staining (yellow-brown) in children of mothers given t drug during the latter half of pregnancy, and in children given the d during the neonatal period, infancy and early childhood. Enamel h plasia has been seen in a few children. If adverse reaction or idio crasy occurs, discontinue medication and institute appropriate ther Demethylchlortetracycline may form a stable calcium complex in bone-forming tissue with no serious harmful effects reported thus in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should given 1 hour before or 2 hours after meals, since absorption is impa by the concomitant administration of high calcium content drugs, fo and some dairy products. Treatment of streptococcal infections sh continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, New York

345-8

Maryland State
Medical Journal

VOLUME 18 NOVEMBER 1969 NUMBER 11

CONTENTS:

Legalized Marijuana? 60

The Changing Status of Adolescents in the Modern World, Margaret Mead, PhD 61

"If we examine human development, as the human species became established as the species we know today, one of the most interesting developments has been the changing lengths of the various portions of the life cycle, as the period of early maturation was extended and human beings attained greater longevity. Among these developments, the postponement of puberty is one of the most important. This postponement allowed a longer period in which children, untroubled by the urgencies of puberty, could devote themselves to mastering the increasingly complex human culture. Today, children are reaching puberty at an earlier age, and the roles of children, young people, and adults in the present-day world are rapidly changing."

Cephaloridine Dosage in Infants and Children, Stuart H. Walker, MD, and Victoria T. Maisog, MD 65

"Cephaloridine, a semi-synthetic derivative of cephalosporin C, possesses the same range of antibacterial effectiveness as other cephalosporins, but produces less tissue reaction when injected intramuscularly, is less serum bound, possesses a longer serum half-life, and appears to penetrate the bacterial cell more rapidly. Cephaloridine has been demonstrated to be regularly effective in the treatment of gram-positive coccal infections, and less regularly effective in the treatment of gram-negative bacillary infections."

Sudden Unexpected Death in Infants, Gilbert E. Corrigan, MD, with a preface by Russell S. Fisher, MD 70

"Sudden unexpected death in infancy, or crib death, as it is frequently called, is responsible for nearly half of all deaths in infants between the ages of 3 weeks and 12 months. Although the examination of cytological specimens from the tissues and organs studied at autopsy is not a routine procedure, such an examination is made in cases of sudden unexpected death (SUD), since the results of such histological studies are often equivocal and debatable."

Season and the Onset of Acute Childhood Leukemia, James J. H. Carey, MD, and F. Robert Fekety, Jr., MD 73

"The hospital records of 96 children with leukemia seen at The Johns Hopkins Hospital were reviewed to determine whether there was any seasonal variation in the onset of the disease. By date of diagnosis, there was an excess of cases from June to September. By date of clinical onset, there was an excess of cases from May to August. Various artifactual causes of the phenomenon were considered, but were not supported. The seasonal variation was most prominent in children living in the Greater Baltimore Area, in Caucasians, in girls, in children with acute lymphocytic or stem-cell types of leukemia, and in children whose parents were less than 35 years old.

DEPARTMENTS:

Your Medical Faculty at Work, John Sargeant 78

Ethics Corner—Charge Cards and Medicine 79

Library Page—Help, Help! 89

Baltimore City Health Department—New Appointments 91

Tuberculosis Section—Survival of Acute Respiratory Failure 93

Maryland State Department of Health—Medical Assistance Advisory Committee 97

Maryland State Department of Mental Hygiene—Capacity, Patient Population Size and Occupancy Rates 101

Heart Page—Reasons for Renal Allograft Success as Compared to Heart Transplants, Robert M. Ollodart, MD 105

Alcoholism Section—A Man Named Tufti/Some Thoughts on Police Officers, Diabetics, and Alcoholics, Judge Irving B. Zeichner 107

Rehabilitation Notes—Spinal Cord Injuries, Douglas G. Carroll, MD 113

EDITORIAL and BUSINESS OFFICE: 211 Cathedral Street, Baltimore, Maryland 21201. 539-872 (Area Code 301). ©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland. Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

ON THE COVER: This month's cover is printed with the permission of **The Catholic Review.** Photo by **Kathleen Graham.**

Doctors Take Note **5**

Executive Secretary's Newsletter **9**

Scientific Exhibit Reservation Form **13**

New Medicaid Regulations **17**

Heart Association Fellowships and Grants **26**

Book Reviews **35**

MEDIC **47**

Medical News **49**

Sports Seminar **53**

Orient Tour **54**

Annual Meeting Information **59**

Woman's Auxiliary **103**

Information for Authors **117**

Advertising Index **119**

Classified Advertising **120**


When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
1 PINT (473 cc.) M-148
ILOSONE® LIQUID
ERYTHROMYCIN ESTOLATE ORAL SUSPENSION, U.S.P.
125
SHAKE WELL BEFORE USING
REFRIGERATE
AVOID FREEZING
ILOSONE® LIQUID
250
ILOSONE®
125
100 PULVULES® No. 374
ILOSONE®
ERYTHROMYCIN ESTOLATE CAPSULES, N.F.
125 mg.
50 TABLETS No. 1834
ILOSONE®
CHEWABLE
125 mg.
100 PULVULES® No. 375
ILOSONE®
ERYTHROMYCIN ESTOLATE CAPSULES, N.F.
250 mg.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company, Indianapolis, Indiana 46206.
900541

Doctors take note...

NOVEMBER 20, 1969
UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

Postgraduate Course—Hypertension & Renal Disease. Director: Glenn D. Lubash, MD. Designed for the practitioner of medicine, the course deals with the newer concepts and techniques in the treatment of hypertension and renal disease. For further information, contact: The Committee on Continuing Medical Education of the University of Maryland School of Medicine, 522 W. Lombard St., Baltimore, Maryland 21201.

NOVEMBER 20-22, 1969
TEXAS HEART ASSOCIATION/AMERICAN HEART ASSOCIATION

Special Scientific Session: Mexico City. For further information, contact: Heart Association of Maryland, 415 North Charles St., Baltimore, Maryland 21201.

NOVEMBER 17-21, 1969
WORLD FEDERATION OF MENTAL HEALTH/NATIONAL ASSOCIATION FOR MENTAL HEALTH

World Mental Health Assembly: Shoreham Hotel, Washington, D.C. For further information, contact: Paul V. Lemkau, MD, Chairman, 615 North Wolfe St., Baltimore, Maryland 21205.

NOVEMBER 30, 1969
INTERNATIONAL COLLEGE OF SURGEONS/INTERNATIONAL SURGERY

Journalism award for the best scientific paper submitted by a surgical resident. A $500.00 cash award is being made available through a grant from Carroll J. Bellis, MD, a Fellow of the International College of Surgeons. For further information, write: Surgical Resident Award Program, International Surgery, 1516 N. Lake Shore Drive, Chicago, Ill. 60610.

NOVEMBER 30-DECEMBER 3, 1969
THE AMERICAN MEDICAL ASSOCIATION

Clinical Convention: Convention Center Complex, Denver, Colorado. The convention will include scientific sessions and the showing of 25 medical motion pictures. Write: The American Medical Association, 535 North Dearborn St., Chicago, Ill. 60610.

DECEMBER 3, 1969
MARYLAND KIDNEY FOUNDATION

Seminar—Dialyzable Poisons: University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. Speaker: John F. Maher, MD, Professor of Medicine, Director, Division of Nephrology, University of Missouri School of Medicine. The seminar will begin at 5:00 PM.

DECEMBER 4, 1969
THE ARTHRITIS FOUNDATION

Scientific Session: Pioneer Hotel, Tucson, Arizona. For further information, contact: Mrs. Judy Shugar, AHPS Executive Secretary, Arthritis Foundation, 1212 Avenue of the Americas, New York, New York 10036.

DECEMBER 5-6, 1969
THE ARTHRITIS FOUNDATION

Scientific Session of the American Rheumatism Association: Pioneer Hotel, Tucson, Arizona. An all-day scientific workshop for physicians will be held on December 4. Contact: Miss Margaret Walsh, ARA Executive Secretary, Arthritis Foundation, 1212 Avenue of the Americas, New York, New York 10036.

DECEMBER 6-11, 1969
THE AMERICAN ACADEMY OF DERMATOLOGY

Meeting: Americana Hotel, Bal Harbour, Florida. The AAD meeting will include two days of postgraduate courses in clinical dermatology and cutaneous biology, an all-day symposium, a Residents' Forum, and a series of breakfast and luncheon conferences. For information, write: The American Academy of Dermatology, 2250 NW Flanders, Portland, Oregon 97210.

DECEMBER 8-12, 1969
HAHNEMANN MEDICAL COLLEGE AND HOSPITAL

21st Symposium—Emergency Medical Care: Marriott Motor Hotel, Philadelphia, Pa. Directors: Stanley Spitzer, MD, and Wilbur W. Oaks, MD. Contact: Sage Cordell, Assistant Director, Continuing Education, Hahnemann Medical College and Hospital, 230 North Broad St., Philadelphia, Pa. 19102.

DECEMBER 9, 1969
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Dialytic Therapy of Renal Failure: University of Maryland Hospital, Psychiatric Institute, Room 1-704, Baltimore, Md. Speaker: Dr. Lewers. The conference will begin at 4:00 PM.

DECEMBER 16, 1969
MARYLAND SOCIETY FOR THE RHEUMATIC DISEASES

Meeting and Discussion—Surgical Therapy of Rheumatic Diseases: Osler Hall, 1211 Cathedral St., Baltimore, Md. 21201. Speaker: Thomas H. Morgan, MD, The Johns Hopkins Hospital.

JANUARY 7-27, 1970
AMERICAN COLLEGE OF SURGEONS

1970 Scientific Winter Cruise. The cruise itinerary will cover the Caribbean area, with Sectional Meetings to be held in San Juan, Caracas, and Panama City. Fellows interested in participating should write to the College's travel agent: Thomas McGuire Enterprises, Inc., 230 North Michigan Ave., Chicago. Ill. 60601.

CAMP, CHARIS, KELLOGG
CORSET SHOP
Dorothy P. Barnes
ORTHOPEDIC, SURGICAL & MATERNITY GARMENTS
PRESCRIPTIONS FILLED PROMPTLY
BRACES & SURGICAL SUPPLIES
BRAS, GIRDLES
PERSONAL FITTINGS BY APPOINTMENT
Over 23 years experience
2318 N. Charles St. 467-8441
If no answer, call 448-4004
Baltimore, Md. 21218

COLOSTOMY
ILEOSTOMY
Appliances and Disposable Bags
CALL
FIELDS PHARMACY
IN PIKESVILLE
for convalescent supplies and service
FOR RAPID DELIVERY 486-3300



the price maker's
prices on the new '70 Dodges
beat all other prices
without Arithmetricks

CENTRAL DODGE
1111 Cathedral Street
Phone 685-3797
OPEN DAILY 9 TO 9
SATURDAYS 9 TO 6

P.D.Q. SERVICE ESPECIALLY FOR DOCTORS *Professional, Dependable, Quick Auto Repairs. Our service department has instructions to give precedence to doctors in immediate, accurate electronic diagnosis and prompt, expert therapy on any make car to avoid unnecessary delay in your valuable service to the community.*

Inexpensive
Effective



HEAD HALTER TRACTOR KIT

Recommended for traction treatment of:

1. Syndromes caused by slipped cervical discs.
2. Certain fractures of cervical vertebrae.
3. Certain types of tuberculosis of the spine, in preparation for, instead of or after fusion of the spine.
4. Certain cases of neck-muscle spasm.
5. Temporary measure until a cervical brace is prepared.

DONALD O. FEDDER, ORTHOTIST

Rents and Sells
Hospital Equipment

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

First Aid To The Worried



In both of our stores we relieve you of all the shopping tension.

Make your jewelry selections in a pleasant atmosphere, with salespeople who are understanding and who make your Christmas shopping really enjoyable.

If you can't come in—call us, we will do your shopping for you.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
Tidewater Inn., Easton, Md. (TA 2-1553)

Specializing in the

fitting of shoes

for proper foot function

and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday
and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.

ADVANCE FUR SALE!

Take your selection home for three days **to inspect it and make your decision.**

When you have confirmed your selection we will store your fur free of charge.

Your decision need not be final until you take your fur out of storage.

Your purchase MUST BE completely satisfactory

Maryland's Exclusive Representative for

Oleg Cassini
FURS



Mano Swartz

225 N. Howard St.
Baltimore, Md. 21201

LE 9-4900

executive secretary's newsletter

November, 1969

ANNUAL MEETING RESOLUTIONS

Resolutions for consideration at the Annual Meeting of the House of Delegates, set for April 1, 2, 3, 1970 must be received in the Faculty Office

NO LATER THAN, FRIDAY, FEBRUARY 6, 1970

TRIENNIAL REGISTRATION

Triennial Registration for physicians is being handled on an alphabetical basis.

All registration notices for surnames beginning A through G were mailed in March of 1969 and any physician in this group who has not renewed his license will be considered as practicing invalidly. Surnames H through N will be mailed in March, 1970 and must be renewed by October, 1970; O through Z will be mailed in March, 1971 and must be renewed by October, 1971. Note: The current certificate is valid until the deadline date of your specific group.

SCIENTIFIC EXHIBITS 1970

Physicians interested in displaying a scientific exhibit at the Faculty's Annual Meeting, April 1, 2 and 3, 1970, should contact the Chairman of the Committee on Program and Arrangements, DeWitt E. DeLawter, MD, at the Faculty office. (See page 13 for form).

WE NEED YOUR HELP

Going into the mail to all members in the near future is a reply postal card asking for information on your desires as to committee assignments for the 1970-1971 Faculty year.

Only by letting the President-elect know of your willingness to serve on committees, can the most be obtained from the entire membership. By such service you can also get to know your society better and help solve the problems which are common to us all.

NEWS NOTES

Physicians, selected on a random basis, are to be asked by a questionnaire their "Attitudes Towards Nurse-Midwives". The survey is being conducted by a student at The Johns Hopkins School of Hygiene and Public Health, as material for his doctoral dissertation.

U.S. Department of HEW has 386 advisory committees consisting of 5,308 persons, such "advice" costing

NEWS
NOTES
(cont'd)

$7,093,290, this year. For fiscal 1971, a total of 5,514 persons are expected to "advise" at a cost of $7,225,487.

Cooperation between the medical profession and the new Secretary of Health and Mental Hygiene has reached one of the highest levels ever. Continuous communication on important health objectives results in finely-meshed activities and results.

Regional workshops have been scheduled for December in Philadelphia (9th) and New York City (11th) to discuss the Professional Activities Study and the Medical Audit Program now in use in many Maryland hospitals. Full details are available from the Faculty office.

The Study on Perinatal Mortality is getting into full swing with the mailing of material asking for contact person in all hospitals with obstetrical services. The ultimate aim is careful analysis of such deaths and development of educational activity to reduce the incidence.

Faculty committee members are working closely with members of the Podiatry Association in an evaluation of hospital privileges, and the Faculty's position in this regard.

Also hard at work are members of another subcommittee discussing the question of publicity efforts on the part of Maryland hospitals in their attempt to recruit patient for specialized research studies.

The Legislative program for the 1970 General Assembly is now being developed within the Legislative Committe While few Faculty-germinated items of legislation will be introduced, it is evident that legislators during the coming session will see increased emphasis on health matters.

The Secretary of Health and Mental Hygiene is developing ways and means to improve delivery of health care to recipients of Medicaid. The proposal is aimed at reducing the incidence of hospitalization, which is the single most expensive item in the Medicaid budget. Plans are underway for some type of peer review mechanisms for professional services, but with limited amount of data available from Medicaid program this is difficult to implement.

John Sargeant
Executive Secretary

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And free your secretary to be your secretary again.

professional systems and services *division of*

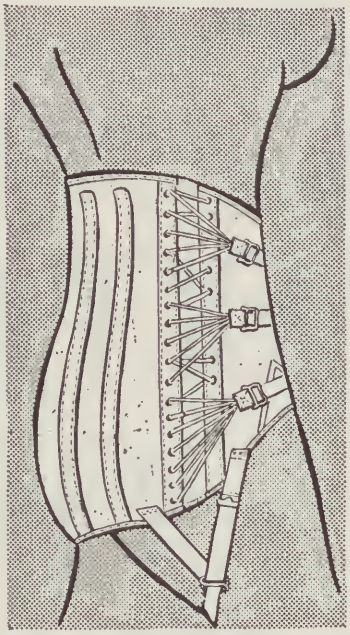
CC

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3896



FEMALE SACRO-LUMBAR SUPPORT

WHITE BROCADE or DACRON MESH

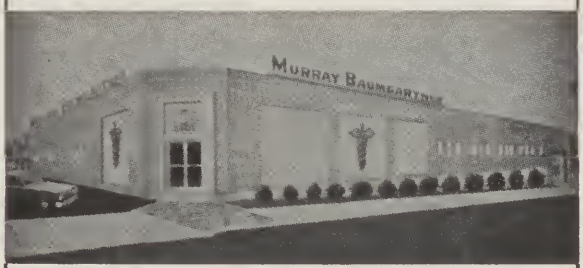


MODEL 42—Custom type garment tailored for corrective support of the sacral and lumbar areas.

SPECIFICATIONS: White brocade material. Solid back with two 13" removable para spinal steels. Sides laced with three sets of adjusting straps and nylon lacers. Hook and eye opening at left side of front. Size range 24-40. Even sizes only.

SEE OUR COMPLETE LINE OF SURCICAL APPLIANCES

- Cervical Collars
- Arch Supports
- Sacroiliac Belts
- Trusses
- Colostomy and Urinary Appliances



Murray-Baumgartner

SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.
Phone: 669-9300 Baltimore, Md. 21216

Serving the Medical Profession for Almost Half a Century

Baltimore's Gourmet mail order seafood house offers shipments of fresh Chesapeake Bay Seafood . . .

anywhere in the country



. . . to the home, with customer satisfaction guaranteed. Shipments arrive in perfect condition or we reship at our expense or refund.

Chesapeake Farm Inc.
110 NORTH EUTAW STREET
BALTIMORE, MARYLAND 21201
685-8882 LOCATED AT LARKIN'S SEAFOOD

SCIENTIFIC EXHIBITS

The scientific exhibits are an integral part of the Annual Meeting of the Medical and Chirurgical Faculty. All physicians who have a scientific exhibit are urged to fill in the application below for the next Annual Meeting, which will be held

APRIL 1, 2, 3, 1970
The Alcazar, Baltimore

As space is limited, it is suggested that applications be submitted as soon as possible.

RULES GOVERNING SCIENTIFIC EXHIBITS

The following rules govern the selection and conduct of scientific exhibits:

1. Each exhibitor shall be fully responsible for the content, arrangement, presentation, setting up, and dismantling of his exhibit.
2. Cost of transportation of exhibit to and from the meeting must be borne by the exhibitor.
3. The Medical and Chirurgical Faculty will provide, without cost to the exhibitor, a backdrop and side rails for the booth, and 1000 watt electric current outlets.
4. MOTION AND SOUND MAY BE USED ONLY IF THEY DO NOT DETRACT FROM OTHER EXHIBITS, DISTURB THOSE IN ROOM, OR INTERFERE WITH TELEPHONES.
5. No reference to, or credit for, financial aid shall be shown on the exhibit.
6. Only generic names may be used, and shall not exceed one inch in height. NO TRADE NAMES are permissible.
7. Each exhibit should be manned at all times by someone thoroughly familiar with its content.
8. Exhibitors are urged to discuss their displays and work with the physicians and students.
9. The Medical and Chirurgical Faculty reserves the right to approve or reject any exhibit without recourse.

APPLICATION FOR SCIENTIFIC EXHIBIT SPACE

Fill in and mail to: Chairman, Exhibit Subcommittee
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore, Md. 21201

1. Title of exhibit: _____

_____

2. Please attach a 50-100 word description of the exhibit: _____

3. Give amount of space required, depth, width, and height: _____

If exhibit has side panels, are depth and width included above? _____

If not, what additional space is required? _____

4. Electrical or other requirements: _____

_____

5. Has exhibit been shown at other medical meetings? _____

_____

6. Name and title of exhibitor: _____

_____

7. Name of institution cooperating in the exhibit: _____

_____

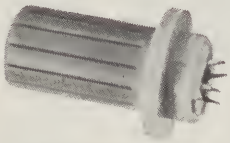
8. Address of exhibitor: _____

_____

SEE RULES GOVERNING SCIENTIFIC EXHIBITS

TB is still around.

In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?

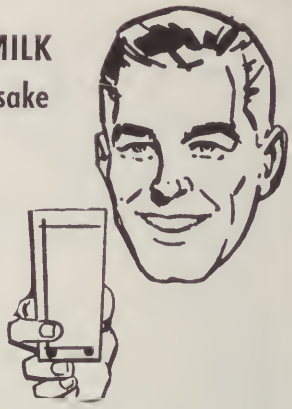


TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.

DRINK MORE MILK
for your health sake



- More Vitamins
- More Minerals
- More Energy



Deliveries in Maryland, Washington and Virginia.

Looks Delicious, Tastes Beautiful.

EMBASSY DAIRY
DU 7-1441
1620 First St. N.W.
Washington, D.C.

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected for possible growth of principal and income.

NO SALES CHARGE
NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

ABBEY RENTS
SICKROOM EQUIPMENT

Prompt, professional service 24 hours a day, every day! A complete line of hospital beds, wheelchairs, traction equipment, oxygen, crutches, walkers, commodes, lamps, whirlpools—everything to help patients get well faster.

We Process MEDICARE Equipment Claims.

358-3400
6316 Reisterstown Road
Baltimore

The AMBAR® SCRAPBOOK of

Obesity Oddities

FACT & LEGEND



CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSE

AMBAR #2 EXTENTABS®

methamphetamine HCl 15 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/**Indications:** Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

A. H. ROBINS COMPANY, RICHMOND, VA. 23220 A·H·ROBINS



heavenly relief
for unearthly cough

Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69

New Medicaid Regulations Set

The regulations on Medicaid payments, published in the Federal Register on July 1, establish a ceiling on government payments to physicians under the Title 19 program.

It does not reduce fees currently paid under Medicaid programs, and in certain cases allows states to increase payments if they have been substandard.

The regulations do, however, make use of a payment ceiling which will utilize the Consumer Price Index (CPI) to keep up with the changing economy.

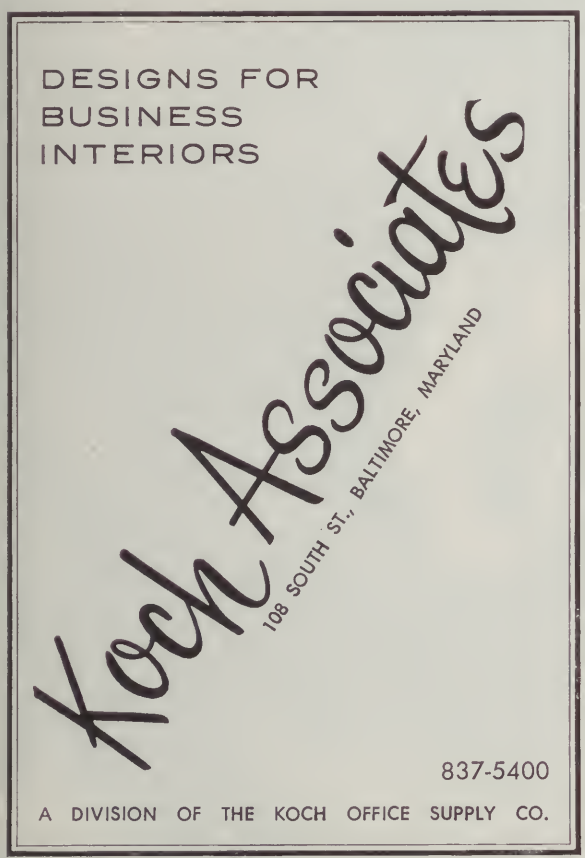
The public had 30 days to comment on the regulations, which are summarized as follows:

1. Levels of Medicaid payment as of January 1, 1969, may not be exceeded.
2. States paying less than the 75th percentile of customary charges, based on data of January 1, 1969, may increase payments up to the 75th percentile as approved by the secretary.
3. If Medicaid payments, as of January 1, 1969, exceed the Medicare Part B level, payments must be reduced to the Medicaid level.
4. Increases after July 1, 1970, will be limited to the percentage increase in the all-services component of the CPI.
5. If on July 1, 1970, a state is paying at a level which is less than the 75th percentile (based on January 1, 1969 data), it may go to the 75th percentile, plus the increase in the CPI.
6. If on July 1, 1970, a state is paying at the 75th percentile, it may increase the payments based on the increase in the CPI.
7. If a state is paying more than the 75th percentile, it cannot effect an increase until the 75th percentile (based on January 1, 1969 data) plus the increase in the CPI, exceeds the level of its payments on January 1, 1969.

With regard to the use of the CPI, the administration recognizes that there may be some problems in its application. Therefore, studies will be undertaken to develop a mechanism to allow Medicaid payments to keep up with the economy.

While Medicaid payments have received most of the headlines, the real key to economy under the program is utilization review.

Carriers, intermediaries, or single state agencies administering the program will be required to set up with local medical societies effective ways to review the necessity and quality of care furnished under the Medicaid program.





THE BREAKUP of a business partnership, the crack-up of a marriage, the shake-up of being fired or reduced to bankruptcy... after any significant loss or severe blow to self-esteem, *both* anxiety and depression almost always follow.





FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

For prescribing information, including indications, contraindications, warnings, precautions, and side effects, please see following page.

FOR MODERATE TO SEVERE ANXIETY WITH COEXISTING DEPRESSION

TRIAVIL®

TRANQUILIZER-ANTIDEPRESSANT

Containing perphenazine and amitriptyline HCl

TRIAVIL®2-25: Each tablet contains 2 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®4-25: Each tablet contains 4 mg. of perphenazine and 25 mg. of amitriptyline hydrochloride.

TRIAVIL®2-10: Each tablet contains 2 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

TRIAVIL®4-10: Each tablet contains 4 mg. of perphenazine and 10 mg. of amitriptyline hydrochloride.

INDICATIONS: Patients with moderate to severe anxiety and/or agitation and depressed mood; patients with depression in whom anxiety and/or agitation are severe; patients with depression and anxiety in association with chronic physical disease; schizophrenics with associated depressive symptoms.

CONTRAINDICATIONS: Central nervous system depression from drugs (barbiturates, alcohol, narcotics, analgesics, antihistamines); bone marrow depression; urinary retention; pregnancy; glaucoma. Do not give in combination with MAOI drugs because of possible potentiation that may even cause death. Allow at least 2 weeks between therapies. In such patients therapy with TRIAVIL should be initiated cautiously, with gradual increase in the dosage required to obtain a satisfactory response.

WARNINGS: Patients should be warned against driving a car or operating machinery or apparatus requiring alert attention, and that response to alcohol may be potentiated.

PRECAUTIONS: Suicide is always a possibility in mental depression and may remain until significant remission occurs. Supervise patients closely in case they may require hospitalization or concomitant electroshock therapy. Untoward reactions have been reported after the combined use of antidepressant agents having various modes of activity. Accordingly, consider possibility of potentiation in combined use of antidepressants. Not recommended for use in children. Mania or hypomania may be precipitated in manic-depressives (perphenazine in TRIAVIL seems to reduce likelihood of this effect). If hypotension develops, epinephrine should not be employed,as its action is blocked and partially reversed by perphenazine. Caution patients about errors of judgment due to change in mood.

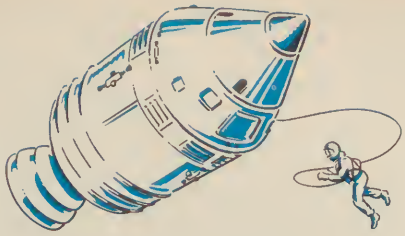
SIDE EFFECTS: Similar to those reported with either constituent alone.

Perphenazine: Should not be used indiscriminately. Use caution in patients with history of convulsive disorders or severe reactions to other phenothiazines. Likelihood of untoward actions greater with high doses. Closely supervise with any dosage. Side effects may be any of those reported with phenothiazine drugs: blood dyscrasia (pancytopenia, thrombocytopenic purpura, leukopenia, agranulocytosis, eosinophilia); liver damage (jaundice, biliary stasis); extrapyramidal symptoms (opisthotonos, oculogyric crisis, hyperreflexia, dystonia, akathisia, dyskinesia, parkinsonism) usually controlled by the concomitant use of effective antiparkinsonian drugs and/or by reduction in dosage, but sometimes persist after discontinuation of the phenothiazine; severe acute hypotension (of particular concern in patients with mitral insufficiency or pheochromocytoma); skin disorders (photosensitivity, itching, erythema, urticaria, eczema, u to exfoliative dermatitis); other allergic reactions (asthma laryngeal edema, angioneurotic edema, anaphylactoid reactions); peripheral edema; reversed epinephrine effect; endocrine disturbances (lactation, galactorrhea, disturbances of menstrual cycle); grand mal convulsions cerebral edema; altered cerebrospinal fluid proteins; polyphagia; paradoxical excitement; photophobia; skin pigmentation; failure of ejaculation; EKG abnormalities (quinidine-like effect); reactivation of psychotic processes catatonic-like states; autonomic reactions such as drynes of the mouth, headache, nausea, vomiting, constipation, obstipation, urinary frequency, blurred vision, nasal congestion, and a change in the pulse rate; hypnotic effects; pigmentary retinopathy; corneal and lenticular pigmentation; occasional lassitude; muscle weakness; mild insomnia; significant unexplained rise in body temperature may suggest intolerance to perphenazine, in which case discontinue. Antiemetic effect may obscure signs of toxicity due to overdosage of other drugs or make diagnosis of other disorders such as brain tumors or intestinal obstruction difficult. May potentiate central nervous system depressants (opiates, analgesics, antihistamines, barbiturates, alcohol), atropine, heat, and phosphorous insecticides.

Amitriptyline: Careful observation of all patients recommended. Side effects include drowsiness (may occur within the first few days of therapy); dizziness; nausea; excitement; hypotension; fainting; fine tremor; jitteriness; weakness; headache; heartburn; anorexia; increased perspiration; incoordination; allergic-type reactions manifested by skin rash, swelling of face and tongue, itching; numbness and tingling of limbs, including peripheral neuropathy; activation of latent schizophrenia (however, the perphenazine content may prevent this reaction in some cases); epileptiform seizures in chronic schizophrenics; temporary confusion, disturbed concentration, or transient visual hallucinations on high doses; evidence of anticholinergic activity, such as tachycardia, dryness of mouth, blurring of vision, urinary retention, constipation, paralytic ileus; agranulocytosis; jaundice. The antidepressant activity may be evident within 3 or 4 days or may take as long as 30 days to develop adequately, and lack of response sometimes occurs. Response to medication will vary according to severity as well as type of depression present. Elderly patients and adolescents can often be managed on lower dosage levels.

For more detailed information consult your Merck Sharp and Dohme representative or see the package circular.

MSD | **MERCK SHARP & DOHME**
Division of Merck & Co., Inc., West Point, Pa. 19486
where today's theory is tomorrow's therapy



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



Appearances may be deceiving



It may be tetracycline

but it's not ACHROMYCIN® V
Tetracycline HCl

unless it bears this signature.



250 mg. and 100 mg. capsules

Contraindications: Hypersensitivity to tetracyclines. *Warning:* In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs. *Precautions:* Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

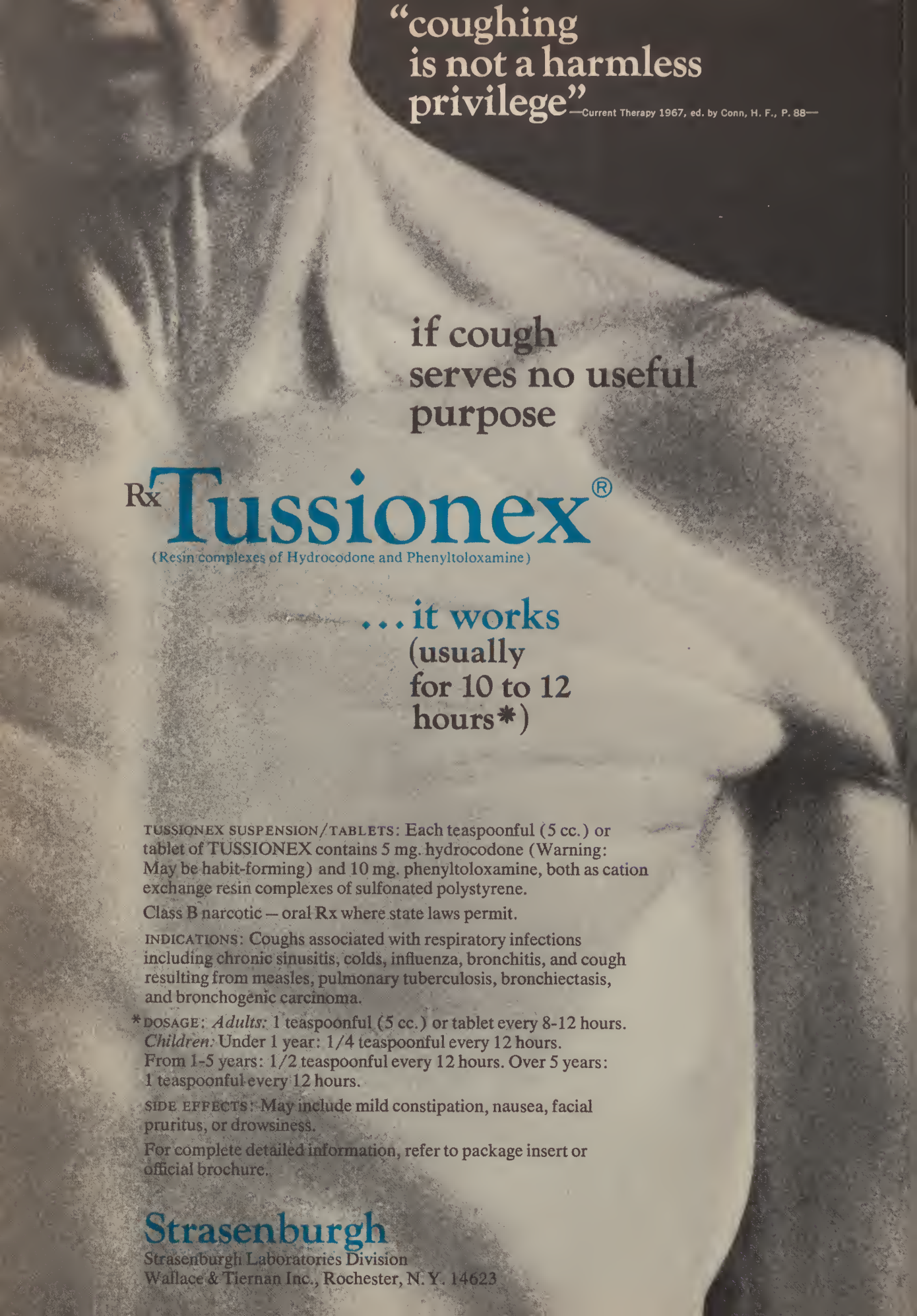
Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

530-9


"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—
if cough serves no useful purpose
℞ Tussionex®
(Resin complexes of Hydrocodone and Phenyltoloxamine)
. . . it works (usually for 10 to 12 hours*)
TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.
Class B narcotic — oral Rx where state laws permit.
INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.
*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.
For complete detailed information, refer to package insert or official brochure.
Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N. Y. 14623

Dulcolax®...so predictable you can almost set patients by it.

Dulcolax works so effectively that the time of bowel evacuation can often be predicted.

Dulcolax tablets taken at night will usually result in a convenient bowel movement the following morning. Dulcolax suppositories generally work within 15 minutes to an hour.

Dulcolax may be given to the aged, pregnant or nursing women, and children. It may be particularly helpful in conditions in which straining should be avoided. The drug, however, is contraindicated in the acute surgical abdomen.

Dulcolax® bisacodyl



R LICENSE FROM BOEHRINGER INGELHEIM G.M.B.H. GEIGY PHARMACEUTICALS. DIVISION OF GEIGY CHEMICAL CORPORATION, ARDSLEY, NEW YORK 10502 DU-6681

December 1st Deadline for Research Fellowships and Grants-in-Aid

Applications are being accepted by the American Heart Association for research support for the fiscal year, July 1, 1970 to June 30, 1971 or July 1, 1970 through June 30, 1972. Deadline for applications is December 1, 1969.

RESEARCH FELLOWSHIPS: To encourage young scientists and to support their early years of investigative work in the field of Cardiovascular research.

Term: 1-2 years; Basic Stipend: $7,000 no post-doctoral training; $7,500, one year post-doctoral training; $8,000—two or more years post-doctoral training; $500, each dependent, no limit; $500, travel and supply grant; $500, additional for second year award.

GRANTS-IN-AID: To support an investigator's research project in a qualified non-profit institution in Maryland.

Term: 1-2 years; Award: Maximum $6,000 (plus 10% institutional overhead).

For information and application forms, write: Heart Association of Maryland, 415 North Charles Street, Baltimore, Maryland 21201.

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- SIDE GRIPPER
- SET IN BACK BELT

#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#801—65 Poly./35 cot. Tricot **$6.99**

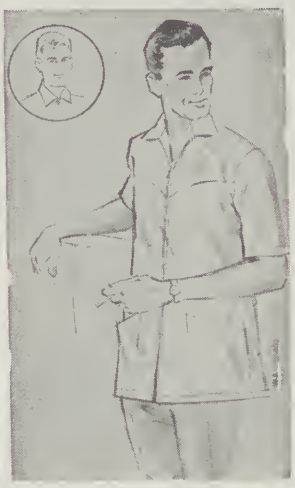
#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only

Sizes 34 to 46



Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200



MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab **$9.99**

Sizes 28-40

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

- ZIPPER FRONT
- SET IN BACK BELT
- CONVERTIBLE COLLAR
- LARGE PATCH POCKETS

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$7.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46



Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639

OTHER STORES IN →



Skilled Hands

Skilled hands at Jobst Service Centers expertly measure your patient for a custom-made Jobst *Venous Pressure Gradient*® Support!

And *your* own prescription determines the precise counter-pressures to be built-in each garment! These selected counter-pressures can aid in moving pooled venous and lymph fluids, and offer a treatment of *choice* for varicose ulcers, varicose veins, stasis dermatitis, postmastectomy lymphedema, postphlebitic syndrome, post fracture, postoperative and injury edema.

Jobst Prescription *Venous Pressure Gradient* Supports include stockings, lymphedema sleeves and waist-high garments of many types. Jobst also makes special garments for unusual conditions.



For a complete data file on Jobst Garments, send coupon at right. Or even quicker, just call the phone number shown.

© Jobst 1969

Jobst Service Center

Suite 200, 818 Eighteenth Street, N.W.
Washington 20006, Phone (202) 298-5530

Suite 415, Medical Arts Bldg., 101 W. Read St.
Baltimore 21201, Phone (301) 539-0560

Name _____

Institution _____

Address _____

City, State, Zip _____

- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE
EVANGELICAL
PRESS
THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"



BOLTON HILL *Dinner Theatre*

Oct. 21 - Nov. 16 "Crack of Doom"

Nov. 18 - Dec. 14 "The Odd Couple"

Dinner – 7 P.M.
Performance – 8:30 P.M.
FREE PARKING
CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
5 PM — 2 AM

for Reservations
call 728-0800

Baltimores Only Professional Dinner Theatre

OVER 60 YEARS OF FRIENDLY SERVICE

Arundel Federal

Savings and Loan Association
ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE
DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily
Tuesday Evenings 7 to 9

355-9300

PATAPSCO AVENUE & FOURTH STREET
Baltimore, Maryland, 21225

DOCTORS' OFFICES

LARGE
MEDIUM
SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST. CORPORATION

11 E. Chase St.
Phone 539-8553



Painful night leg cramps...

unwelcome bedfellow for any patient– including those with arthritis, diabetes or PVD

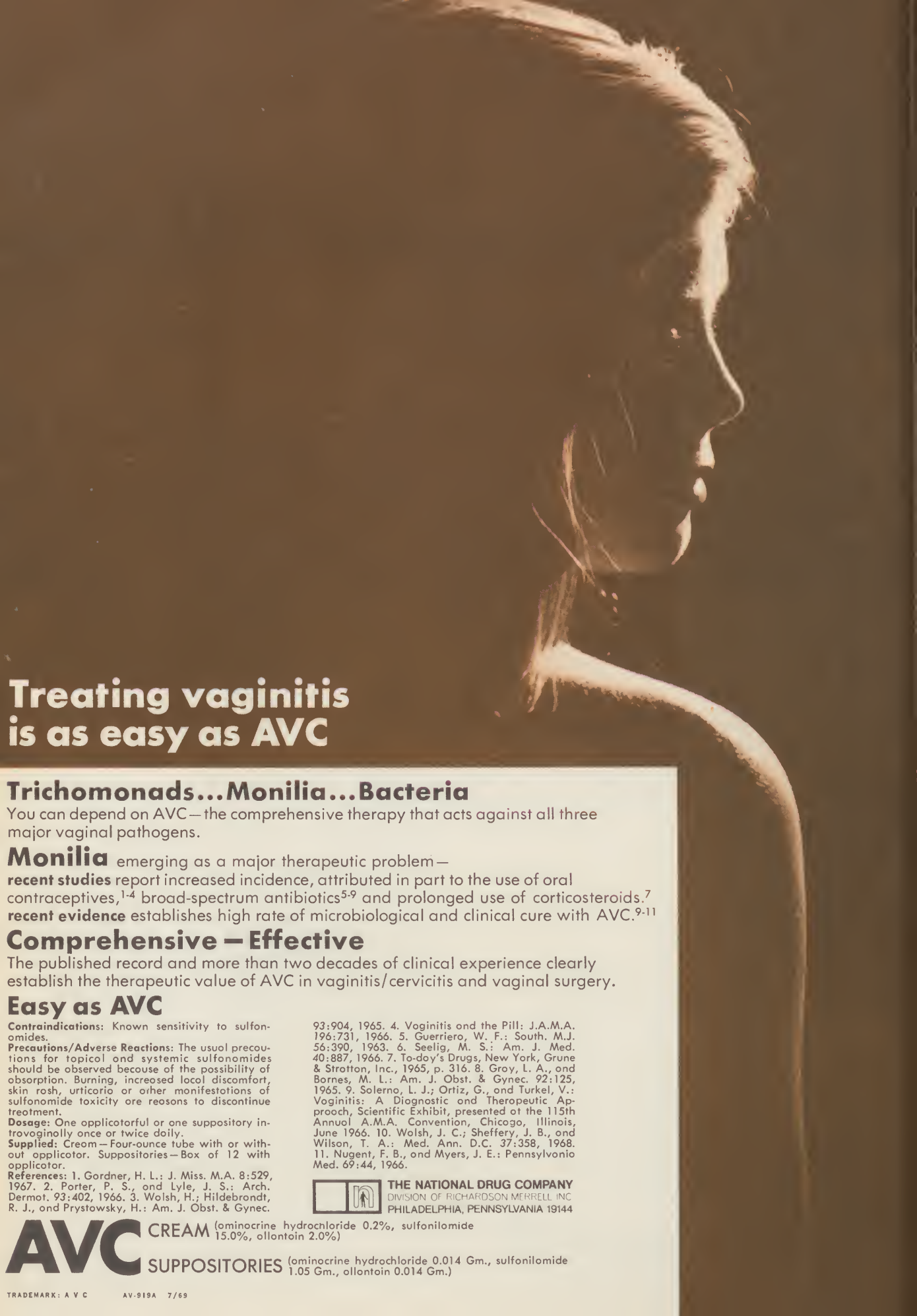
One thing patients can sleep without, particularly patients with chronic disease conditions such as arthritis, diabetes or PVD, is painful night leg cramps. Although seldom the presenting complaint, night leg cramps can tie your patients up in painful knots. Now, just one tablet of QUINAMM at bedtime can usually bring an end to shattered sleep and needless suffering. Your patients will sleep restfully—gratefully—with QUINAMM, specific therapy to prevent painful night leg cramps.

Prescribing Information—Composition: Each white, beveled, compressed tablet contains: Quinine sulfate, 260 mg., Aminophylline, 195 mg. **Indications:** For the prevention and treatment of nocturnal and recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis and static foot deformities. **Contraindications:** QUINAMM is contraindicated in pregnancy because of its quinine content. **Precautions/Adverse Reactions:** Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. Discontinue use if ringing in the ears, deafness, skin rash, or visual disturbances occur. **Dosage:** One tablet upon retiring. Where necessary, dosage may be increased to one tablet following the evening meal and one tablet upon retiring. **Supplied:** Bottles of 100 and 500 tablets.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144

Quinamm™
(quinine sulfate 260 mg., aminophylline 195 mg.)

Specific therapy for night leg cramps



Treating vaginitis is as easy as AVC

Trichomonads...Monilia...Bacteria

You can depend on AVC—the comprehensive therapy that acts against all three major vaginal pathogens.

Monilia emerging as a major therapeutic problem—
recent studies report increased incidence, attributed in part to the use of oral contraceptives,[1-4] broad-spectrum antibiotics[5-9] and prolonged use of corticosteroids.[7]
recent evidence establishes high rate of microbiological and clinical cure with AVC.[9-11]

Comprehensive—Effective

The published record and more than two decades of clinical experience clearly establish the therapeutic value of AVC in vaginitis/cervicitis and vaginal surgery.

Easy as AVC

Contraindications: Known sensitivity to sulfonomides.
Precautions/Adverse Reactions: The usuol precoutions for topicol ond systemic sulfonomides should be observed becouse of the possibility of obsorption. Burning, increosed locol discomfort, skin rosh, urticorio or orher monifestotions of sulfonomide toxicity ore reosons to discontinue treotment.
Dosage: One opplicotorful or one suppository introvoginolly once or twice doily.
Supplied: Creom—Four-ounce tube with or without opplicotor. Suppositories—Box of 12 with opplicotor.

References: 1. Gordner, H. L.: J. Miss. M.A. 8:529, 1967. 2. Porter, P. S., ond Lyle, J. S.: Arch. Dermot. 93:402, 1966. 3. Wolsh, H.; Hildebrondt, R. J., ond Prystowsky, H.: Am. J. Obst. & Gynec. 93:904, 1965. 4. Voginitis ond the Pill: J.A.M.A. 196:731, 1966. 5. Guerriero, W. F.: South. M.J. 56:390, 1963. 6. Seelig, M. S.: Am. J. Med. 40:887, 1966. 7. To-doy's Drugs, New York, Grune & Stratton, Inc., 1965, p. 316. 8. Groy, L. A., ond Bornes, M. L.: Am. J. Obst. & Gynec. 92:125, 1965. 9. Solerno, L. J.; Ortiz, G., ond Turkel, V.: Voginitis: A Diognostic ond Theropeutic Approoch, Scientific Exhibit, presented ot the 115th Annuol A.M.A. Convention, Chicogo, Illinois, June 1966. 10. Wolsh, J. C.; Sheffery, J. B., ond Wilson, T. A.: Med. Ann. D.C. 37:358, 1968. 11. Nugent, F. B., ond Myers, J. E.: Pennsylvonio Med. 69:44, 1966.

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON MERRELL INC
PHILADELPHIA, PENNSYLVANIA 19144

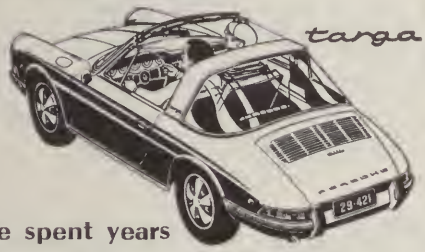
AVC CREAM (ominocrine hydrochloride 0.2%, sulfonilomide 15.0%, ollontoin 2.0%)

SUPPOSITORIES (ominocrine hydrochloride 0.014 Gm., sulfonilomide 1.05 Gm., ollontoin 0.014 Gm.)

TRADEMARK: A V C

AV-919A 7/69

PORSCHE



Porsche spent years developing a great competition car so you could have fun driving to work.



Both body styles available in four engines:
911T
911E - 911S

Sportomatic available on 911 series only

40 West VOLKSWAGEN
Phone: 744-2300
6624 Baltimore National Pike
West of Beltway Exit 15 on Rt. 40 West

THE FOOD...
THE SERVICE...
THE ATMOSPHERE

—all superb at Baltimore's outstanding Spanish Restaurant

RESTAURANTE TIO PEPE

10 E. FRANKLIN ST. BALTIMORE, MD. 21202
Phone 539-4675

MONDAY THROUGH THURSDAY
Luncheon 11:30 – 2:30
Dinner 5 P.M. – 10:30 P.M.

FRIDAY & SATURDAY
Dinner 5 P.M. – 11:30 P.M.

SUNDAY
Dinner 4 P.M. – 10:00 P.M.

★ This extended care Nursing Home is Approved by the Joint Commission on Accreditation of Hospitals
★ One story new fire-safe construction.
★ No steps, ramps or elevators needed.
★ Inspection invited. Reasonable rates.
★ All facilities available to private physicians.

Where your convalescent
Elderly, Bedfast or Disabled

Enjoy being special

V. I. P.'s

(VERY IMPORTANT PARENTS)



★ Professional Total Care Program.
★ Continuous Physical Rehabilitation by registered therapists in specially equipped department.

PHONE VALLEY 8-6500

Dulaney Towson
NURSING & CONVALESCENT HOME
111 West Road, Towson
Off York Rd. Beltway Exit 26 South

ARE YOU CONFUSED
about the best Keogh plan
FOR YOU?

As a Physician you can take advantage of the Keogh Act in many ways:

Special Government Bonds

Combination of Life Insurance and Investments

Custodian Account with a Bank

Trust Funds with a Bank

Life Insurance or Annuity Contracts

Mutual Fund Shares

Each plan has its advantages—But which one is best for you depends upon your circumstances.

For Consultation CALL . . .

The Griffin Agency

Connecticut Mutual Life INSURANCE COMPANY

17 Light Street

Baltimore, Maryland 21202

752-6740

NOW

A NEW CONCEPT

in

BOOKEEPING

and

TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

SECURITY BUSINESS SERVICES, INC.

Box 335
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager

Comprehensive First-Aid Chart Offered

The American Academy of Pediatrics has released a newly-revised comprehensive first-aid chart which provides invaluable information on treatment of harmful injuries that most commonly occur among youngsters.

The chart has been prepared by the Academy's Committee on Accident Prevention and Subcommittee on Accidental Poisoning. It contains comprehensive information on first-aid treatment for convulsions, burns and scalds, puncture wounds, head injuries, choking and other injuries.

Measuring 11″ x 17″, the new chart is colorfully illustrated to accentuate the pertinent data presented. There is also a convenient place on the chart for the family physician's phone number.

Individual copies may be obtained for 20 cents a chart. The chart is also available at a 10% discount for quantities of 6 or more. Larger quantity prices are available upon request. Copies may be obtained by writing to: Publications, American Academy of Pediatrics, P.O. Box 1034, Evanston, Illinois 60204.

Library Exhibit on Cushing

Because 1969 is the 100th anniversary year of his birth, Dr. Harvey Cushing—the man most frequently cited as the father of neurosurgery—is being honored as the subject of an exhibit by the American College of Surgeons to be on display in the College Library through December.

Emphasizing Dr. Cushing's outstanding contributions to medicine in general, and to neurosurgery in particular, the exhibit will be comprised of books, photographs, notes, letters, and other memorabilia grouped into both panel and case displays.

Dr. Cushing's early life and family background will be recorded, together with significant documentation of his early surgical training with Dr. William S. Halsted, father of the residency system of training.

The exhibit will include drawings and sketches of surgical problems and therapy essayed by this outstanding surgeon. Also, it will emphasize his influence in later years on the Yale Historical Library.

The College's Library exhibits are open to the public as an educational service to the community and to visitors to the College.



BLUE SHIELD® provides more benefits per member dollar

Last year Maryland Blue Shield members got back 90¢ in medical care for every dollar paid in.

More than $20 million was paid out on behalf of over a million Marylanders. Blue Shield can pay more benefit dollars because nobody in the voluntary medical care prepayment field has lower operating expenses.

The remarkable benefits which Blue Shield can offer its members confirm the foresight of the doctors who originated this unique health care program. Through your continuing cooperation, Maryland Blue Shield remains the best basic value for your patients.

To find out how Blue Shield strengthens the doctor-patient relationship, use the convenient coupon.

Maryland Blue Shield®

7800 York Road
Baltimore, Maryland 21203

Please send me my free copy of your booklet on Blue Shield.

Name_____

Address_____

City_____ State_____ Zip_____



CURRENT PRACTICE IN ORTHOPEDIC SURGERY, John P. Adams, MD; The C. V. Mosby Company, St. Louis, Mo. 1969.

This is the fourth volume in a series designed to update physicians, particularly orthopedists, in the current orthopedic practices and new developments since the last publication.

It consists of various papers presented by different authors, all experts in their particular area, all of which are contained in the last part of the book. The first portion, entitled Section 1, is devoted to a History of American Orthopedic Surgery and consists of papers dealing with Henry Gassett Davis, MD, 1807-1896; Lewis Albert Sayre, MD, 1820-1900; and DeForest Willard, MD, 1846-1910.

For these three sketches, alone, the book is well worth ordering.

A SYNOPSIS OF CONTEMPORARY PSYCHIATRY, 4th EDITION, George A. Ulett, MD, and D. Wells Goodrich, MD; The C.V. Mosby Company, St. Louis, Mo. 1969.

This handbook was written to fill the need for a brief, introductory text of psychiatry as a quick reference for psychiatric residents, medical and psychology interns, medical students, nurses and others whose work in the psychiatric clinic and hospital may be for a brief period of time.

With these people in mind, the handbook has been made small enough to fit in the side pocket of the clinic coat.

The material is organized into three general areas; (a) history taking and diagnostic procedures (b) clinical syndromes and (c) therapeutic measures. For a concise, purposeful text on psychiatry this certainly fills the bill and it is highly recommended both for its usefulness, as well as for its brevity and conciseness.

AS I SAW IT, Sylvan M. Shane; Lowry & Volz, Baltimore, Md. 1969.

AS I SAW IT *in The Soviet Union, in Israel, in Auschwitz, in Anesthesiology, in Dentistry, in Politics* is a kaleidoscope view of the highlights of Dr. Shane's life and times as they relate to his two specialties—anesthesiology and dentistry. Strongly autobiographical, the book sketches the author's career from "his struggle against poverty and his ardent effort to acquire a good education" to his invention of the *Breathaphone*, and the early days when anesthesiology was becoming a recognized medical specialty to Dr. Shane's political ventures—"I became a candidate for the U.S. Congress."

The forward, by Dr. John C. Krantz, Jr., professor emeritus of pharmacology, University of Maryland School of Medicine, is a detailed curriculum vitae of Dr. Shane.

The book is an entertaining and enlightening addition to any library and has been described as "a liberal education between two hard covers."


Danny's
formal wear
Specializing in fine formal clothing
RENTED and SOLD
6218 Reisterstown Rd.
(2 blks. South of Reisterstown Plaza)
FLeetwood 8-1142
Baltimore, Md. 21215

WHEN YOUR PATIENTS NEED NURSING CARE
Call Milton 4-6060

Alice Weber
Baltimore Nurses Exchange
LICENSED & BONDED
24 HOUR SERVICE
ESTABLISHED 1935
BALTIMORE, MARYLAND 21229



help her break an emerging habit pattern...

GYNOREST®
(DYDROGESTERONE)

helps break the emerging habit pattern of nonorganic primary dysmenorrhea.

Early relief of primary dysmenorrhea in the adolescent may lessen its tendency to become a habit pattern "which is very difficult to interrupt."* Dydrogesterone proves to be "...an extremely satisfactory drug...the most conservative type of progestational agent..."* for relief of severe and incapacitating dysmenorrhea in adolescents.

Gynorest provides these distinct advantages

normal cycles usually undisturbed... no inhibition of ovulation...occasional breakthrough bleeding can usually be controlled by dosage adjustment

mild, infrequent side effects... withdrawal is seldom required

freedom from estrogenic and androgenic effects... progestational in action

Mead Johnson
LABORATORIES

Contraindications No serious untoward reactions to Gynorest have been reported and there are no known contraindications to its use. There have been no adverse effects observed clinically on the hepatic, renal, or hemopoietic systems. **Precautions** Before hormonal treatment is considered in patients with excessive or abnormal uterine bleeding, the cause of such bleeding should be determined on an individual basis. Appropriate procedures should be used to determine whether an organic lesion or systemic disease is the cause of the bleeding. Although never reported for Gynorest, it should be borne in mind that other progestogens have been observed to cause fluid retention which on occasion may result in exacerbated attacks of epilepsy, migraine or asthma. **Adverse Reactions** Gynorest appears to be nontoxic. Mild gastrointestinal complaints such as nausea, diarrhea, or constipation have rarely been reported, but have not necessitated withdrawal of the drug. There have been no endocrinologic side effects such as masculinization of a female fetus, virilization of a female patient, or any corticosteroid activity reported from the use of Gynorest. Breakthrough bleeding can usually be controlled by increasing the dosage or by giving the drug in smaller doses at more frequent intervals to maintain a more constant blood level. **Dosage and Administration** Complete details are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied** 10 mg. White Scored Tablets, bottles of 100, or 5 mg. White Scored Tablets, bottles of 50.

*Jones, Georgeanna S.: Maryland Med. J. 16:45, 1967.

© 1969 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 65969

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

★ INGLESIDE SHOPPING CENTER
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ HILLENDALE SHOPPING CENTER
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

Brentwood Inn

FRENCH CONTINENTAL CUISINE

Smorgasbord Luncheon and Dinner
every Tuesday . . . . .

"Home of Maryland's Internationally Famous Wine Cellar" . . . .

We honor all preferred Credit Cards

● ***NEW!*** Another Dining Room has been added to accommodate our many guests ●

OPEN DAILY & SUNDAY 11 A.M. to 2 A.M.

Fifth Ave. & Brentwood—1 block N. E. of Dundalk and Holabird Ave. 1 mile from Holabird Ave. Exit of Baltimore Harbor Tunnel

We cater to Private Parties, Banquets and Dinners

AT. 5-0520 *Ample Free Parking* **BALTIMORE, MD. 21222**

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA
Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*

or

CHARLES W. NEVILLE, JR., M.D.
Assistant Professor of Psychiatry and Medical Director

Area Code 704—254-3201

TRED AVON WATERFRONT



SAILORS: Here's a unique residential parcel affording

6 ft. anchorage MLW
240 ft. dock
boathouse
magnificent tall timbers
artesian well
road in

It's well worth $45,000 . . .
Let us show it to you.

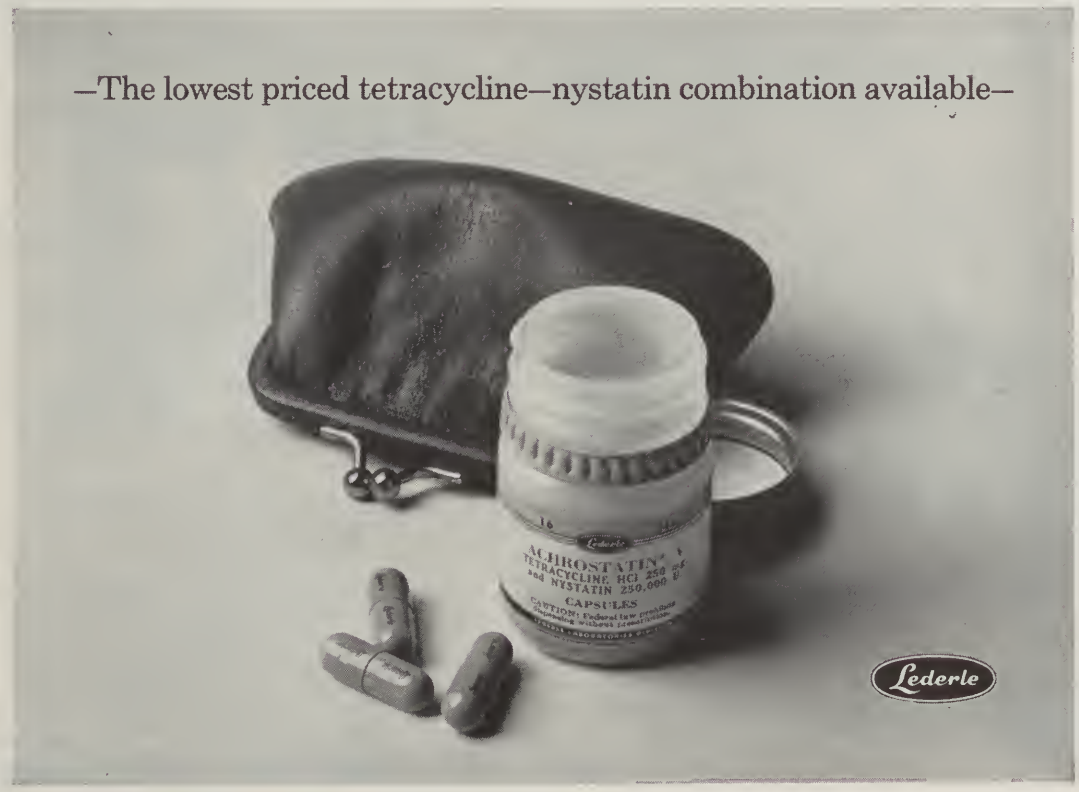
HELAINE WHITE, Realtor
Easton, Maryland **(301) 822-4626**

Third ACS TV Film Takes Up Subject of Teen-ager Sports Injuries

"To Win or to Play," the most recent public service film prepared by the American College of Surgeons for television showing, is the third in a series of four which the Board of Regents has authorized for production this year.

In sound and color, this one-minute film uses animated cartoons to stress the dangers of undue parental pressure and forced competitive spirit in sports activities involving the growing teen-ager. It takes its theme (and title) from an article on the subject, written by Nicholas J. Giannestras, Cincinnati, and printed originally in the July-August 1967 issue of the College BULLETIN.

Written by the College's communications staff, the film has been produced in the studios of Rick Reinert Productions, Cleveland. It will be released to some 200 television stations across the country.



Ec-
on-
omy!

Dicarbosil®
ANTACID

Your ulcer patients and others will appreciate it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

SKILLED MEDICAL ASSISTANTS
and
MEDICAL RECEPTIONISTS
are now available from

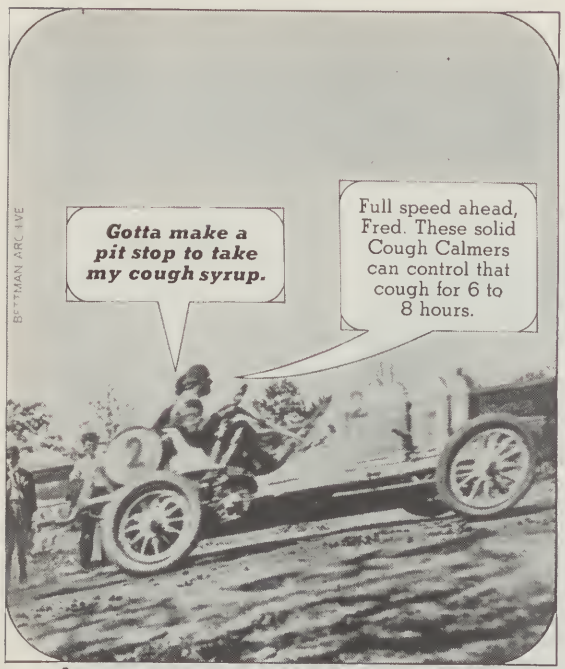


THE BRYMAN SCHOOL

. . . a part of the nation's largest network of schools specializing in preparing women for auxiliary positions in medicine.

Telephone 821-5222

32 WEST ROAD TOWSON, MARYLAND 21204





Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg. A. H. Robins Company, Richmond, Virginia 23220

A·H·ROBINS

Mercedes-Benz does not make conventional cars... and never will!

TOWSON VALLEY MOTORS
Mercedes-Benz
103 E. Pennsylvania Ave., Towson (just behind Hutzler's) 821-8000

BLOOD PLAN
of the
METROPOLITAN WASHINGTON
BLOOD BANKS, INC.
Not For Profit
A BLOOD DONATION TODAY
PROTECTS YOU AND YOUR
FAMILY TOMORROW

- A Medically Supervised Blood Benefit Program
- Individual—Family—Group Memberships

T. A. Loosbrock, Exec. Dir.

915 19th St. N.W., Suite 500 Phone 737-0060
Washington, D.C. 20006

IN BALTIMORE.....

House In The Pines Nursing Homes have the facilities and experience to care for those you care for



HOUSE IN THE PINES
NURSING HOMES

PROFESSIONAL CARE FOR THE AGED, CHRONICALLY ILL AND CONVALESCENT.

• Bright, pleasant surroundings and a home-like atmosphere • Fire-safe accommodations • Competent professional care, 24 hours a day • Complete Physical and Occupational Therapy facilities and programs under the direction of our licensed staff therapists

• Modern kitchens supervised by licensed staff dietitian provide tasty, balanced meals.

BEL AIRE — 5837 Belair Road — CL 4-8800
BELVEDERE — 2525 W. Belvedere Ave. — FO 7-9100
CATONSVILLE — 16 Fusting Ave. — RI 7-1800
also Easton, Md., Rt. 50 & Dutchman's Lane. TA 2-4000

YOUR INSPECTION INVITED • BROCHURE ON REQUEST

A & F Nurses Registry



LICENSED & BONDED

- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.
BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery

MU 5-3232

D. Stuart Webb

Advertising Services, Inc.

306 N. Gay Street Baltimore, Md. 21202

BALTIMORE OXYGEN SUPPLY CO., INC.

OHIO CHEMICAL DISTRIBUTORS

Therapy and Medical Gases
and Oxygen Tents
Resuscitators and Apparatus

Main Office & Plant: Linthicum, Md. 789-8100
Warehouse: 1611 Guilford Ave., Baltimore, Md. 727-4748
Branch: 2426 Linden Lane, Silver Spring, Md. 582-2094

BERNHARDT L. PIELKE
CLARA L.
LANDSCAPE SERVICE



Give your home new beauty with

SKILLFUL LANDSCAPING

TREES, PLANTS, SHRUBBERY
expertly planned and planted
FREE ESTIMATES

BELTWAY GARDEN CENTER

7937 Belair Road, Baltimore Md. 21236 NO 8-3965

KATHERINE ROBB

Nursing Home

REST HOME For Aged and Convalescents

4105 Essex Rd. near Liberty Rd.

HUnter 6-5656 BALTIMORE, MD.



MITCHELL'S

MARYLAND CORN!

Garden Flavor Guarded

F. O. Mitchell & Bro., Inc.
Perryman, Maryland
Phone Perryman 272-3636
Plant Phone
Perryman 272-3637

STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

We Repair and make Lamps
"Lamps make the home Beautiful"

LE 9-0222 403 N. Charles Street
Baltimore, Md. 21201

Baltimore's most unusual dining place!

Famous
Owl Room



Belvedere Hotel

Charles & Chase Streets

now he can cope...

thanks to

Butisol SODIUM®
(SODIUM BUTABARBITAL)

the "daytime sedative" for everyday situational stress

When stress is situational—environmental pressure, worry over illness—the treatment often calls for an anxiety-allaying agent which has a prompt and predictable calming action and is remarkably well tolerated. BUTISOL SODIUM (sodium butabarbital) meets this therapeutic need.

After 30 years of clinical use . . . still a first choice among many physicians for dependability, safety and economy in mild to moderate anxiety.

Contraindications: Porphyria or sensitivity to barbiturates.

Precautions: Exercise caution in moderate to severe hepatic disease. Elderly or debilitated patients may react with marked excitement or depression.

Adverse Reactions: Drowsiness at daytime sedative dose levels, skin rashes, "hangover" and systemic disturbances are seldom seen.

Warning: May be habit forming.

Usual Adult Dosage: As a daytime sedative, 15 mg. (¼ gr.) to 30 mg. (½ gr.) t.i.d. or q.i.d.

Available for daytime sedation: Tablets, 15 mg. (¼ gr.), 30 mg. (½ gr.); Elixir, 30 mg. per 5 cc. (alcohol 7%).

BUTICAPS® [Capsules BUTISOL SODIUM (sodium butabarbital)] 15 mg. (¼ gr.), 30 mg. (½ gr.).

McNEIL

McNeil Laboratories, Inc., Fort Washington, Pa.





No place for beginners

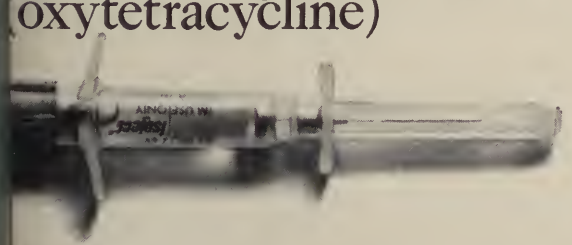
Terramycin®
(oxytetracycline)

Fire victim. Examination reveals second degree burn of lower leg. To combat shock, restore circulatory volume and replace protein loss, plasma is administered. Local pressure dressing applied. Limb elevated to limit the flow of lymph. About 36 hours after admission the patient develops an elevated temperature and complains of pain at the site of the lesion. Dressing removed. A suppurating slough area has developed over part of the burn. A swab specimen is taken for culture and the slough area is debrided. Antibacterial treatment is begun with Terramycin I.M. Days later, recovery is progressing, and the laboratory report shows a mixed infection with a predominance of susceptible coliform bacteria, confirming the therapeutic choice. Terramycin therapy is continued until all signs of infection disappear.

Experience has shown that Terramycin offers special advantages in treating bacterial infections complicating burns, when strains of causative organisms are susceptible. Broad-spectrum antibacterial coverage. Activity unaffected by penicillinase. Rapidly achieved therapeutic blood levels. Proven tissue toleration.

Terramycin I.M. is the only preconstituted broad-spectrum antibiotic designed specifically for intramuscular use. Requires no refrigeration. Remains stable for at least two years. Available for immediate use in Isoject,® a disposable injection unit. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Terramycin® I.M.
(oxytetracycline)



Pfizer **LABORATORIES DIVISION**
New York, N.Y. 10017

Contraindicated: In individuals hypersensitive to any of the components of this drug.

Warnings: If renal impairment exists, even usual doses may lead to excessive systemic accumulation and possible liver toxicity. In such patients, lower than usual doses are indicated and for prolonged therapy oxytetracycline serum level determinations may be advisable.

Terramycin may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight. Discontinue therapy at first evidence of skin discomfort.

Note: With oxytetracycline, phototoxicity is not believed to occur and photoallergy is very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy.

As with all intramuscular preparations, Terramycin Intramuscular Solution should be injected well within the body of a relatively large muscle. *Adults:* The preferred sites are the upper outer quadrant of the buttock (i.e., gluteus maximus), or the mid-lateral thigh. *Children:* It is recommended that intramuscular injections be given preferably in the mid-lateral muscles of the thigh. In infants and small children the periphery of the upper outer quadrant of the gluteal region should be used only when necessary, such as in burn patients, in order to minimize the possibility of damage to the sciatic nerve.

The deltoid area should be used only if well developed such as in certain adults and older children, and then only with caution to avoid radial nerve injury. Intramuscular injections should not be made into the lower and mid-thirds of the upper arm. As with all intramuscular injections, aspiration is necessary to help avoid inadvertent injection into a blood vessel.

Increased intracranial pressure with bulging fontanelles has been observed occasionally in infants receiving therapeutic doses of the drug, but such signs and symptoms have disappeared rapidly on cessation of treatment with no sequelae.

Adverse Reactions: Subcutaneous and fat-layer injection may produce mild pain and induration which may be relieved by an ice pack. Very mild gastrointestinal disturbances, not requiring discontinuance of the drug, may occur occasionally. Allergic reactions, including anaphylaxis, rarely have been observed.

Dosage: *Adult:* The optimal dosage varies, depending on the type and severity of infection. Unless otherwise specified, a dose of 100 mg. every 8 to 12 hours, or a single daily dose of 250 mg. should be adequate for the treatment of most mild or moderately severe infections. In severe infections, 100 mg. every 6 to 8 hours, or 250 mg. every 12 hours may be necessary.

Serum levels obtained by the recommended dosages are comparable to those provided by the oral dosage of 1 to 2 Gm. daily in adults. Antibiotic therapy should be continued for at least 24 to 48 hours after all symptoms and fever have subsided.

In certain diseases specific courses of therapy may be recommended as a general guide. In primary and secondary syphilis for example, the daily administration of 2 Gm. oxytetracycline, orally, in divided doses for two weeks has given good results. In cases of gonococcal infection two intramuscular injections of 250 mg. each, or one intramuscular injection of 250 mg. combined with one gram given orally as a single dose, will usually suffice, but repetition of this therapy will be required in an occasional case.

In the treatment of hemolytic streptococcal infections, therapy should continue for at least 10 days to prevent development of rheumatic fever or glomerulonephritis.

In the treatment of staphylococcal infections indicated surgical procedures should be carried out in all cases.

Pediatric: A dosage of 3 mg./lb./day in two doses has been found satisfactory in the treatment of most mild to moderately severe infections. For more severe infections, higher dosages may be indicated and should be adjusted accordingly.

Terramycin Intramuscular Solution provides maximum absorption and patient toleration with minimal local irritation.

Supply: Terramycin (oxytetracycline) Intramuscular Solution: available in single dose, prescored glass ampules containing 100 or 250 mg. oxytetracycline/2 cc., Isoject® syringes containing 100 or 250 mg. oxytetracycline/2 cc. and 10 cc. multiple dose vials containing 50 mg. oxytetracycline/cc.

More detailed professional information available on request.

this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

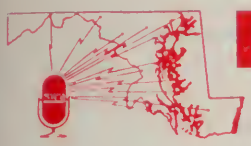
PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48160



MEDIC 1969–1970 SCHEDULE

OF POSTGRADUATE PROGRAMS

presented through

Medical Education's Dedicated Instructional Channel

Supported in part by a grant from Merck Sharp and Dohme

NOVEMBER 21, 1969 — 12:30 PM

PRE-ECLAMPSIA AND ECLAMPSIA

Frank Kaltreider, MD
Chief, Department of Obstetrics and Gynecology
Baltimore City Hospitals

Rafael Garcia, MD
Assistant Chief of Pathology
Baltimore City Hospitals

Pre-eclampsia is a preventable disease. Pre-eclampsia is commonly associated with varied complications. For these reasons warning signs, apparently innocent, cannot be ignored.

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, November 24, 1969	12:30 PM
	Wednesday, November 26, 1969	9:00 AM
		2:00 PM

NOVEMBER 28, 1969 — 12:30 PM

CURRENT IMMUNIZATION PRACTICES

David H. Carver, MD
Associate Professor of Pediatrics
Associate Professor of Microbiology
The Johns Hopkins University School of Medicine

This discussion will deal with a suggested schedule of immunization of children and will emphasize particularly the new vaccines, mainly measles, mumps, and rubella.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:	Monday, December 1, 1969	12:30 PM
	Wednesday, December 3, 1969	9:00 AM
		2:00 PM

DECEMBER 5, 1969 — 12:30 PM

OBESITY

Simeon Margolis, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine
University of Maryland School of Medicine

An increasing number of patients are turning to physicians for assistance in weight reduction and for treatment of the complications of obesity. Management of the obese patient is an extremely frustrating medical problem, but may involve dietary, drug, and psychiatric measures. This talk will cover the pathogenesis, complications, and management of obesity.

Sponsor: SACRED HEART HOSPITAL

Replays:	Monday, December 8, 1969	12:30 PM
	Wednesday, December 10, 1969	9:00 AM
		2:00 PM

DECEMBER 12, 1969 — 12:30 PM

INTERPRETATION OF BRAIN SCANS

Frank H. DeLand, MD
Assistant Professor of Radiology
The Johns Hopkins University School of Medicine

The accumulation of experience over the past decade has enabled us to characterize abnormal accumulations of radioactivity. Histologic diagnosis cannot be made from the brain scans when an abnormal accumulation, as seen in a scan, is nonspecific. However, the nature of the lesion can be inferred, based on its scan characteristics of size, shape, concentration of activity and location.

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:	Monday, December 15, 1969	12:30 PM
	Wednesday, December 17, 1969	9:00 AM
		2:00 PM

DECEMBER 19, 1969 — 12:30 PM

TUBERCULOUS MENINGITIS

Edmund G. Beachman, MD
Assistant Professor of Medicine and
Chief, Tuberculosis Division
Baltimore City Hospitals

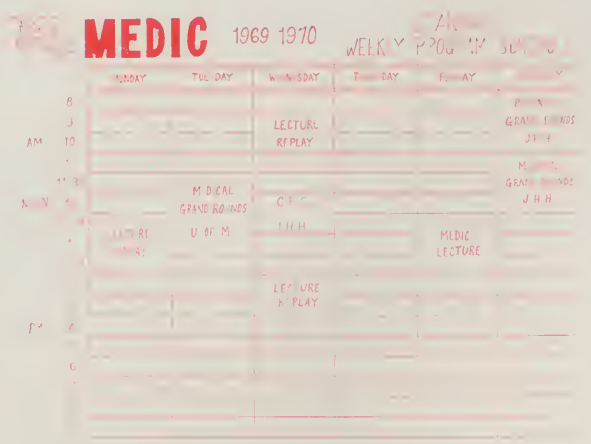
Richard Slavin, MD
Assistant Chief of Pathology
Baltimore City Hospitals

Tuberculous meningitis in children and adults will be approached by both clinical and pathological application.

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, January 5, 1970	12:30 PM
	Wednesday, January 7, 1970	9:00 AM
		2:00 PM

(Continued next page)



CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

November 25	January 27
February 24	March 24
April 28	May 26

OTHER SPONSORS:

Medical and Chirurgical Faculty of the State of Maryland

State Department of Health

Hospital Council of Maryland

Participating hospitals:
Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Physicians Memorial, LaPlata
Prince George's General, Cheverly
Provident, Baltimore
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Veterans Administration, Loch Raven, Baltimore
Washington County, Hagerstown

Other locations:
Baltimore County Health Dept., Towson
Civil Defense Headquarters, Baltimore
Hospital Council of Maryland, Inc., Baltimore
Medical and Chirurgical Faculty, Baltimore
State Department of Health, Baltimore

For further information contact:
Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
(301) 539-0872

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201, (301) 383-3010 Ext. 8722

MANUEL SCHWARTZ
HEARING REHABILITATION
321 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201
DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION
Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

Do Your Patients Need Nursing Service?
Call **889-5666**
COBB-WOODS SERVICES
Vera Woods, M. A. Director
2213 St. Paul St. Baltimore, Md. 21218
Licensed by the State of Md.

MEDICAL NEWS

The American Board of Family Practice has announced that it will give its first examination for certification in various centers throughout the United States. The examination will be given over a two-day period, February 28–March 1, 1970.

Information concerning eligibility for the examination may be obtained by writing to: Nicholas J. Pisacano, MD, Secretary, American Board of Family Practice, Inc., University of Kentucky Medical Center, Annex #2, Room 229, Lexington, Kentucky 40506.

* * *



Dr. Bordley

John E. Bordley, MD, of Baltimore, is executive director and vice-chairman of **The American Council of Otolaryngology,** which recently opened its national headquarters at 1100 17th St. N.W., in Washington, D.C. Wesley H. Bradley, MD, of Syracuse, N.Y., is consultant and assistant to Dr. Bordley.

Dr. Bordley is Andelot Professor Emeritus of Larvngology and Otology, The Johns Hopkins University School of Medicine. He is also Professor of Environmental Medicine, Division of Audiology and Speech, The Johns Hopkins University School of Hygiene and Public Health; and is National Consultant in Otolaryngology to the Surgeon General, U.S. Air Force.

The American Council, founded in September 1968, is the first national body designed specifically to represent otolaryngology through the development of national programs for improved patient care, greater educational opportunities, and to further research.

* * *

On September 25, 1969, a surprise testimonial dinner was given to honor **Mary K. L. Sartwell, MD,** in Bethesda, Maryland. The dinner was organized by the parents of Dr. Sartwell's pediatric patients and by her staff, and was attended by approximately 250 guests. Dr. Sartwell was presented with a plaque commemorating her 25 years as a physician and in appreciation of her services to the community.

* * *

John W. Ferree, MD, MPH, retired September 1st after serving ten years as executive director of the National Society for the Prevention of Blindness. His successor is Wilfred D. David, MD, MPH. Dr. Ferree will continue as a member of the National Eye Institute's Advisory Council, the National Accreditation Council for Agencies Serving the Blind and Visually Handicapped, Illumination Engineering Research Institute, and American Foundation for Overseas Blind.

A graduate of the University of Pennsylvania, Dr. Ferree received his MD degree from the Indiana University School of Medicine and his master's degree in public health from The Johns Hopkins School of Hygiene and Public Health.

* * *

At a meeting of the Baltimore County Dental Society, on September 23, 1969, **Arlie R. Mansberger, Jr., MD,** Professor of Surgery at the University of Maryland Medical School, spoke on the topic "Shock."

Dr. Mansberger received his degree from Western Maryland College in 1943, and earned his MD degree from the University of Maryland School of Medicine in 1947. Author of 73 publications, Dr. Mansberger was Director of Clinical Research (Shock Trauma Unit) at the University of Maryland Hospital from 1962 to 1963.

* * *

George Melville Williams, MD, a specialist in the field of organ transplantation, has been named Chief of Surgery at Good Samaritan Hospital in Baltimore. Dr. Williams was also appointed professor of surgery at The Johns Hopkins University Medical School in July 1969. A graduate of Oberlin College, he received his MD degree from Harvard University in 1957.

Dr. Williams' research interests are immunology and transplantation, and his studies concern tissue immunity and the rejection phenomenon of transplanted organs.

* * *

Harvey Webb, Jr., MD, a specialist in public health dentistry, has been named associate director of the outpatient department of The Johns Hopkins Hospital, and coordinator of outpatient services for the Office of Health Care Programs, a unit of the hospital and The Johns Hopkins University. In this capacity, he will be responsible for coordinating services between the outpatient department of the hospital and health care programs established in the community.

Until his appointment at Johns Hopkins on September 1st, Dr. Webb was assistant professor in the departments of community dentistry at both the University of Maryland and Howard University. Since 1968, he has served as dental coordinator of the Provident Hospital Comprehensive Neighborhood Health Center, and was a member of the dental department staff at Provident.

Dr. Webb received three degrees from Howard University: the BS degree in 1956, DDS degree in 1960, and MS degree in 1962. He was awarded a masters degree in public health in 1967 by The Johns Hopkins University School of Hygiene and Public Health.

* * *

On September 30, 1969, **Maxwell M. Wintrobe, MD,** delivered the 12th annual Tinsley R. Harrison Lecture at the University of Alabama, on the subject "Refractory Anemia 1969." Dr. Wintrobe, Distinguished Research Professor of Internal Medicine at the University of Utah, has served as visiting professor in more than 20 American and foreign institutions and has held memberships in more than 30 health science organizations in addition to 50 national and international scientific committees. He has edited several professional publications, authored over 300 journal articles, and is perhaps best known as the author of *Clinical Hematology,* a widely used medical textbook.

Dr. Wintrobe received his BA, BS, and MD degrees from the University of Manitoba, Canada. He was awarded a PhD degree from Tulane University in New Orleans in 1929. Dr. Wintrobe has served on the faculty of The Johns Hopkins University Medical School as instructor, and later, as associate in medicine. He was also assistant physician, associate physician, and physician-in-charge of the Clinic for Nutritional, Gastro-intestinal and Hemopoietic Disorders at Johns Hopkins.

* * *

Stuart C. Levine, MD, radiologist, has moved his office to: 507 Latrobe Building, 2 East Read Street, Baltimore, Maryland 21202.

* * *

Louis J. Kolodner, MD, has announced the removal of his office for the practice of general surgery to: 6609 Park Heights Avenue, Garden View Apartments, Baltimore, Maryland 21215.

* * *

A **Secretary's Committee on Mental Retardation** has been appointed by the Secretary of Health and Mental Hygiene, **Neil Solomon, MD, PhD.** Harry Shriver, immediate past president of the Baltimore Association for Retarded Children, has been named committee chairman; Lambros D. Callimahos, of New Carrollton, president of the Maryland Association for Retarded Children, has been designated vice-chairman.

The committee will seek to develop a program that will include the initiation or extension of day care services, sheltered workshops, vocational rehabilitation units, halfway houses, residential facilities, training and activity centers, group homes, foster care homes and nursing home care, with emphasis on non-residential facilities. After the plan has been approved, the committee is being asked to design a program to inform the public of the need for increased emphasis on mental retardation activities in the state.



Dr. Solomon

* * *

Theodore H. Kaiser, MD, has opened his office for the practice of child and adolescent psychiatry at: 550 North Broadway, Baltimore, Maryland 21205.

* * *

The United States Pharmacopeial Convention has invited full-time graduate and undergraduate students of accredited pharmacy and medical schools throughout the country to prepare papers on the topic "The USP Role in Improving Drug Therapy." Two awards will be presented: one for the best paper submitted by a pharmacy student, and one for the best paper submitted by a medical student. The winners will each receive an award of $250 and an expense-paid trip to the USPC Sesquicentennial Meet-

ing in Washington, D.C., in April 1970.

For information, write: United States Pharmacopeia, 4630 Montgomery Avenue, Bethesda, Maryland 20014.

* * *

Robert W. Gibson, MD, Medical Director of the Sheppard and Enoch Pratt Hospital, Towson, Maryland, has been appointed to the Commission on the Delivery of Mental Health Services, a division of the American Psychiatric Association. Making the appointment was **Raymond Waggoner, MD,** President of the American Psychiatric Association.

* * *

Senator Gaylord Nelson (D. Wisc.) has introduced a bill that would authorize the Secretary of Health, Education and Welfare to perform tests on all new drugs that are submitted to him. A National Drug Testing and Evaluation Center would be established for this purpose. The Secretary could also contract out drug testing to qualified individuals or institutions. The sponsor of the drug, who would pay for the testing, could request a program report every 60 days. The Nelson bill is now before the Senate Labor and Public Welfare Committee.

* * *

Recently appointed as a Kennedy Scholar, working in the Joseph P. Kennedy Jr. Laboratory for Studies in Mental Retardation at the Johns Hopkins Children's Medical and Surgical Center, is **Guy M. McKhann, MD,** who joined the Johns Hopkins faculty January 1, 1969, as Kennedy Professor and director of the new department of neurology. The Kennedy Foundation will provide $25,000 a year for ten years for Dr. McKhann's work, who will orient his department to investigations of the development of the nervous system and of its normal and degenerative processes.

Dr. McKhann will work with the three other Kennedy Scholars: **David Carter, MD,** associate professor of pediatrics and microbiology; **R. Rodney Howell, MD,** associate professor of pediatrics, and **Hendrik Van der Loos, MD,** associate professor of anatomy.

Robert E. Cooke, MD, director of the department of pediatrics, in which the Kennedy Laboratory is located, said this program at Johns Hopkins has become the major service laboratory resource for the area in researching genetic causes of mental retardation, and is the basis for the new prenatal birth defects detection program now underway and supported by the National Foundation.

* * *

On October 9, 1969, approximately 1,523 surgeons were inducted as new Fellows (members) of the **American College of Surgeons,** in ceremonies held during their annual five-day Clinical Congress in San Francisco.

Among the new Fellows from Maryland are: **Paul Bormel, MD, William H. M. Finney, MD, Roelman W. Immink, MD, Robert H. Johnson, Jr., MD, and Manuel Sanchez, MD, of Baltimore; Bahram Erfan, MD, of Cheverly; Frederick W. Miltenberger, MD, of Cumberland; Ernesto A. Tolentino, MD, of Glen Burnie; Maher W. Ishak, MD, and Henry H. Kwak, MD, of Havre de Grace; Frederick Y. Donn, MD, of Kensington; Nasser Rezai, MD, of Laurel; Walter D. DeVault, Jr., MD, and Nevins W. Todd, Jr., MD, of Salisbury; Martin H. Eichler, MD, Jerry S. Farber, MD, and Leonard L. Kogan, MD, of Silver Spring; and Patrick C. Phelan, Jr., MD, of Towson.**

* * *

Peter Tsairis, MD, who has been a resident in neurology, and **A. M. Karas, MD,** who has been a resident in surgery, both at the Mayo Graduate School of Medicine, University of Minnesota at Rochester, have left that city to reside in Maryland. Dr. Karas will be located in Baltimore, and Dr. Tsairis will be located in Bethesda.

* * *

F. J. Ramsay, MD, has been named Director of the newly-created Office of Research in Medical Education at the University of Maryland School of Medicine. Under his direction, the Office will study the school's present curriculum and plan changes in accordance with the needs of changing medical practice and the demands of a changing society.

In addition to his new post, Dr. Ramsay will continue to teach embryology at the University of Maryland School of Medicine. Dr. Ramsay received his bachelor's degree in biology at Washington and Lee University in Lexington, Va., and his MS and PhD in anatomy at the University of Illinois School of Medicine.

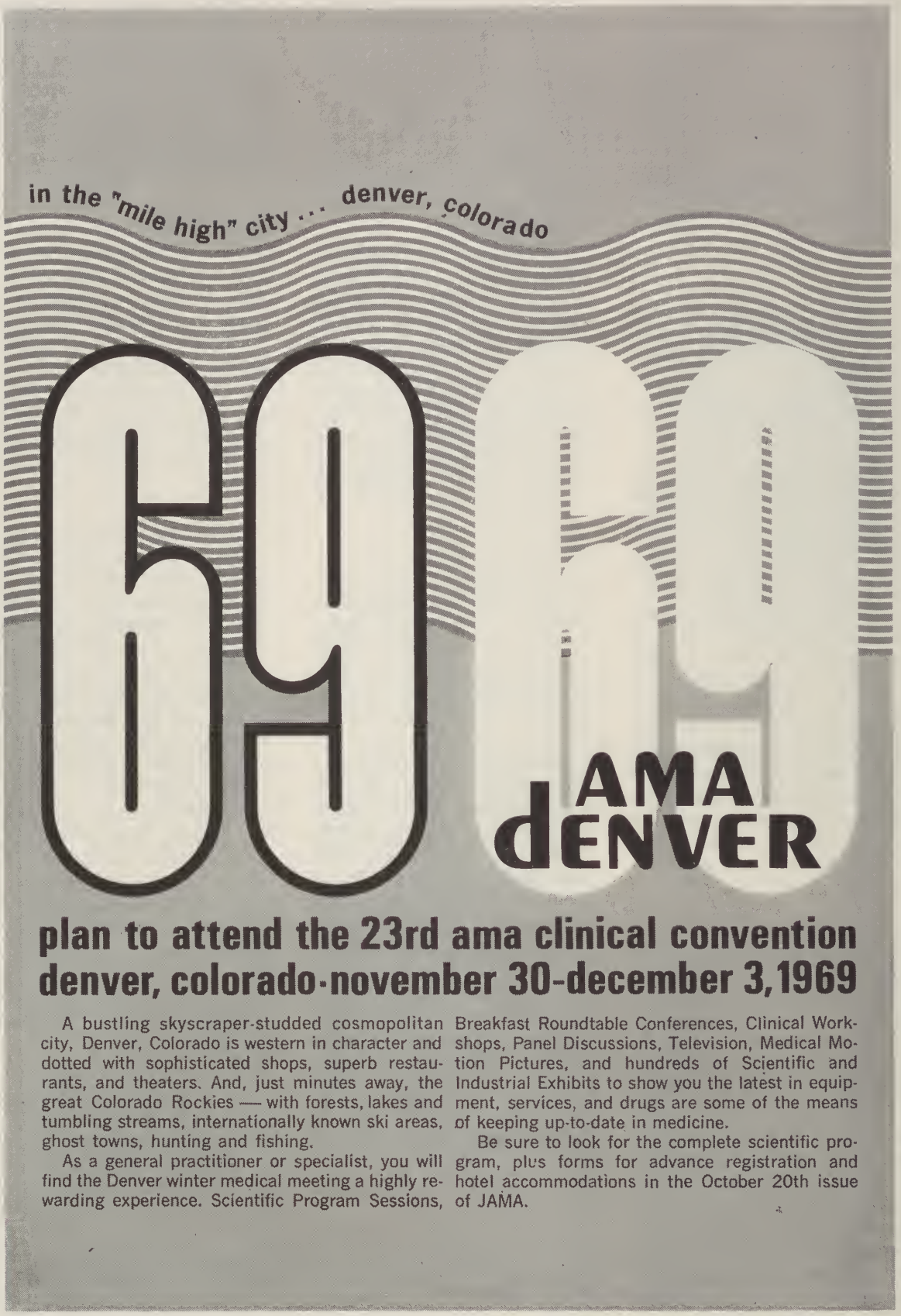
* * *

It's not too soon to make reservations for

Med-Chi's Annual Meeting

April 1, 2, 3, 1970

Call or write the Faculty office for information



plan to attend the 23rd ama clinical convention denver, colorado-november 30-december 3, 1969

A bustling skyscraper-studded cosmopolitan city, Denver, Colorado is western in character and dotted with sophisticated shops, superb restaurants, and theaters. And, just minutes away, the great Colorado Rockies — with forests, lakes and tumbling streams, internationally known ski areas, ghost towns, hunting and fishing.

As a general practitioner or specialist, you will find the Denver winter medical meeting a highly rewarding experience. Scientific Program Sessions, Breakfast Roundtable Conferences, Clinical Workshops, Panel Discussions, Television, Medical Motion Pictures, and hundreds of Scientific and Industrial Exhibits to show you the latest in equipment, services, and drugs are some of the means of keeping up-to-date in medicine.

Be sure to look for the complete scientific program, plus forms for advance registration and hotel accommodations in the October 20th issue of JAMA.

THIRD ANNUAL SEMINAR

ON THE MEDICAL ASPECTS OF SPORTS

Saturday, December 6, 1969 — 9:00 AM to 4:30 PM

Catonsville Community College,
800 South Rolling Road, Catonsville

Chairman of Arrangements
G. Overton Himmelwright, MD, FRCSM

9:00 AM Registration—Classroom Building

10:00 AM Opening Remarks
B. A. Barringer, EdD
President
Catonsville Community College
John F. Schaefer, MD
Chairman, Executive Committee
Medical and Chirurgical Faculty

10:15 AM Room A—**Reflection on the 1968 Olympics Conducted at High Altitude**
Thomas F. Waddell, MD
Georgetown University Hospital
Washington, D.C.

Room B—**Physical Medicine in Athletic Rehabilitation**
Alvin M. Brown, MD
Medical Director
Atlanta Southside Comprehensive Health Center
Atlanta, Georgia

11:30 AM Room A—**Conditioning of the Athlete**
Mr. James Kehoe
Director of Athletics
University of Maryland
College Park, Maryland

Room B—**Neurological Injuries—Field Diagnosis, and Transportation**
Charles W. Henderson, MD
St. Agnes Medical Center
Baltimore, Maryland

12:15 PM Lunch—May be purchased on the campus

1:30 PM. Room A—**Athletic Competition for Women and Teen-Age Girls**
Tenley Albright, MD
Boston, Massachusetts
World and Olympic Figure Skating Champion

Room B—**The Role of "Drugs" in Athletics**
William J. Kinnard, Jr., PhD
Dean, University of Maryland
School of Pharmacy
Baltimore, Maryland

Gary L. Buterbaugh, PhD
Assistant Professor of Pharmacology
University of Maryland School of Pharmacy

2:45 PM Room A—**Psychological and Psychosomatic Problems in the Athlete**
Burris Husman, EdD
Professor of Physical Education
University of Maryland
College Park, Maryland

Room B—**Medicolegal Responsibility for the Athlete by School Administrator, Team Physician, and Coach**
Betty VanderSmissen, ReD, JD
Professor of Recreation
Penn State University
State College, Pennsylvania

3:30 PM Taping Clinics—Conducted on an informal basis so instruction can be more individualized

4:30 PM Adjournment

Program is sponsored by the Medical and Chirurgical Faculty of the State of Maryland and the Division of Health, Physical Education, and Recreation of Catonsville Community College.

3rd Annual Seminar on the Medical Aspects of Sports, December 6, 1969

Detach and return this reservation form to:

Medical and Chirurgical Faculty
1211 Cathedral Street
Baltimore, Maryland 21201

Name .....

Address .....

Enclosed is my check for $.....

($4 per person; students $1. Does not include lunch.)

Make Checks payable to:

Medical and Chirurgical Faculty

Please indicate your preference:

10:15 AM
Reflection on 1968 Olympics _____
Physical Medicine _____

11:30 AM
Conditioning _____
Neurological Injuries _____

1:30 PM
Role of "Drugs" _____
Athletic Competition for Women _____

2:45 PM
Psychosomatic Problems _____
Medicolegal Responsibility _____

MED-CHI TOUR

The Medical and Chirurgical Faculty is sponsoring another exciting tour in the near future:

ORIENTAL CARNIVAL—May 1 to May 17, 1970

A fabulous deluxe tour leaving from Friendship Airport. This is an all-inclusive with six fun-filled days and nights in Tokyo, seven glorious days and nights in Hong Kong, three enchanting days in Honolulu. An opportunity is provided to visit the fabulous 1970 Japan World Exposition in Osaka via the famous "Bullet" train (140 m.p.h.). Included are sightseeing tours, a get-together cocktail party, dinners in restaurants of your choice, breakfasts, and many other attractions.

Make your reservations NOW: For information and reservations contact Mrs. Beverly Wolins, Travel Guide Agency, 416 North Charles Street, Baltimore 21201 (301-727-0680) or Mrs. Genevieve Ritchie, the Faculty office, 1211 Cathedral Street, Baltimore 21201 (301-539-0872).



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

NOW IS THE TIME... TO GIVE HER TIME WITH OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.



The new mother needs time . . .
to adjust to motherhood,
to give her new baby all the love
and attention he requires.
She needs time for her husband . . .
and for herself as well . . .
so that she can come to terms
with the increased cares
and responsibilities now facing her.
She needs time to decide
when she will have additional children
and how many she will have.

OVULEN-21®

Each tablet contains ethynodiol diacetate 1 mg., mestranol 0.1 mg.

GIVES HER TIME

Your prescription for Ovulen-21 gives the new mother time to meet her family's present needs...to plan for her family's future.

She can take Ovulen-21 confidently and comfortably month after month. Its dependability is enhanced by its simplicity of use. A woman needs little or no time to learn the simple Ovulen-21 regimen: three weeks on—one week off. And the automatic record-keeping of the petite, virtually "patient-proof" Ovulen-21 Compack® helps to maintain her schedule...helps put time on her side.

Immediately post partum is the time

It is the time when motivation is highest—when a new mother needs expert advice for the future, so she can space her children and limit her family.

It is also the most opportune time, since she is conveniently present in the hospital, for her to be given both instructions and a prescription.

Non-nursing mothers may begin Ovulen-21 immediately after delivery, on the day of departure from the hospital or at the first postpartum visit, as desired. It is recommended that nursing mothers begin Ovulen-21 four weeks after delivery.

A small fraction of the hormonal agents in oral contraceptive pills has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Indication—Oral contraception.

Contraindications—Thrombophlebitis, thromboembolic disorders, cerebral apoplexy or a past history of these conditions, markedly impaired liver function, known or suspected carcinoma of the breast, known or suspected estrogen-dependent neoplasia, undiagnosed abnormal genital bleeding.

Warnings—Watch for the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, retinal thrombosis); if present or suspected discontinue the drug immediately.

British studies reported in April 1968[1,2] estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and non-users were highly significant. The conclusions reached in the studies are summarized in the table below:

Comparison of Mortality and Hospitalization Rates Due to Thromboembolic Disease in Users and Non-Users of Oral Contraceptives in Britain.

Category	*Mortality Rates*		*Hospitalization Rates (Morbidity)*
	Age 20-34	*Age 35-44*	*Age 20-44*
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Non-Users	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be applied directly to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may differ.

Discontinue medication pending examination if there is sudden partial or complete loss of vision, or sudden onset of proptosis, diplopia or migraine. Withdraw medication if papilledema or retinal vascular lesions are found.

Since the safety of Ovulen in pregnancy has not been demonstrated, it is recommended that pregnancy be ruled out for any patient who has missed two consecutive periods before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule the possibility of pregnancy should be considered at the first missed period.

A small fraction of the hormone agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect on the nursing infant cannot be determined at this time.

Precautions—Pretreatment physical examination should include special reference to the breasts and pelvic organs, and a Papanicolaou smear.

Endocrine and possibly liver function tests may be affected by Ovulen. Therefore, it is recommended that such tests if abnormal be repeated after the drug has been withdrawn for two months.

Pre-existing uterine fibromyomas may increase in size under the influence of progestogen-estrogen preparations.

Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

In breakthrough bleeding, and all irregular vaginal bleeding, consider nonfunctional causes. Adequate diagnostic measures are indicated in undiagnosed vaginal bleeding.

Carefully observe patients with a history of psychic depression and discontinue the drug if severe depression recurs.

Any possible influence of prolonged Ovulen therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

A decrease in glucose tolerance has occurred in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be observed carefully while receiving Ovulen.

Because of the effects of estrogens on epiphyseal closure Ovulen should be used judiciously in young patients in whom bone growth is not complete.

The age of the patient constitutes no absolute limiting factor, although Ovulen therapy may mask the onset of the climacteric.

The pathologist should be informed of Ovulen therapy when relevant specimens are submitted.

Adverse Reactions—A statistically significant association has been shown between use of oral contraceptives and the following serious adverse reactions: thrombophlebitis, pulmonary embolism.

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions: cerebrovascular accidents, neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis.

The following adverse reactions are known to occur in patients receiving oral contraceptives: nausea, vomiting, gastrointestinal symptoms (such as abdominal cramps and bloating), breakthrough bleeding, spotting, change in menstrual flow, amenorrhea during and after treatment, edema, chloasma or melasma, breast changes (tenderness, enlargement, secretion), change in weight, changes in cervical erosion and cervical secretions, suppression of lactation when given immediately post partum, cholestatic jaundice, migraine, allergic rash, rise in blood pressure in susceptible individuals, mental depression.

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted: anovulation post treatment, premenstrual-like syndrome, changes in libido, changes in appetite, cystitis-like syndrome, headache, nervousness, dizziness, fatigue, backache, hirsutism, loss of scalp hair, erythema multiforme and nodosum, hemorrhagic eruption, itching. The following laboratory results may be altered by oral contraceptives: hepatic function: increased sulfobromophthalein and other tests; coagulation tests: increase in prothrombin, Factors VII, VIII, IX and X; thyroid function: increase in PBI and butanol extractable protein bound iodine, and decrease in T^3 uptake values; metyrapone test; pregnanediol determination.



References: 1. Inman, W. H. W., and Vessey, M. P.: Brit. Med. J. 2:193-199 (April 27) 1968. 2. Vessey, M. P., and Doll, R.: Brit. Med. J. 2:199-205 (April 27) 1968.

Before prescribing see complete prescribing information.

Where "The Pill" Began

G. D. SEARLE & CO., P.O. Box 5110, Chicago, Ill. 60680 SEARLE

SC 8 7117 B

972

What's Polycillin® (ampicillin trihydrate) got to do with the price of bananas?

Just this: According to the U.S. Bureau of Labor Statistics, bananas are one of the few things that actually cost less today than five years ago. The same is true of Polycillin. In fact, the price of Polycillin has been reduced about 30% since its introduction in 1963...making it, according to national surveys of patient costs, as economical as leading brands of tetracycline and erythromycin.

And Polycillin is available in a variety of dosage forms for your patients—more than any other ampicillin. It comes in 250 mg. and 500 mg. capsules; in convenient, chewable tablets of 125 mg; oral suspension, 125 mg. and 250 mg. per 5 ml.; and in pediatric drops, 100 mg. per ml. Also available parenterally as Polycillin-N (sodium ampicillin).

BRISTOL LABORATORIES
Division of Bristol-Myers Co.
Syracuse, New York 13201



172nd ANNUAL MEETING

Medical and Chirurgical Faculty of the State of Maryland

APRIL 1, 2, 3, 1970

The scientific sessions of the 1970 Annual Meeting will be held at the Alcazar in Baltimore. Scheduled to present papers are

Daniel M. Gordon, MD
Associate Professor of Ophthalmology
Cornell University Medical College
New York

George James, MD, Dean
Mount Sinai School of Medicine
New York

Roy W. Menninger, MD, President
The Menninger Foundation
Topeka, Kansas

William H. Moretz, MD, Chairman
Department of Surgery
Medical College of Georgia

John Rock, MD
Clinical Professor Emeritus of Gynecology
Harvard Medical School
Director, Rock Reproductive Clinic, Inc.
Cambridge, Massachusetts

Felix Wroblewski, MD
Associate Professor of Clinical Medicine
Cornell University Medical College
New York

Medical and Surgical Grand Rounds will be presented by the Department of Medicine of The Johns Hopkins University and the Department of Surgery of the University of Maryland

Other activities scheduled are

Annual Round-Table Luncheon, which will include luncheon meetings of the alumni associations of several medical schools, and informal scientific discussions

Hospitality Night—this proved so very popular at the 1969 Meeting, that it will be repeated in 1970 at the Belvedere Hotel

Annual Presidential Reception and Banquet—at the Blue Crest North, well known for its delectable cuisine, hors d'oeuvres, and cocktails—in a delightful atmosphere with professional entertainment, and dancing for everyone

Scientific and technical exhibits will be on display each day of Annual Meeting at the Alcazar



Legalized Marijuana?

Anthropologist Margaret Mead, speaking before a Senate subcommittee in late October, condoned legalized marijuana, and suggested that the minimum age for its use should be 16. Saying that its effects are less harmful than alcohol, Dr. Mead criticized the hypocrisy of adults who deny adolescents their own form of escapism, and tell their children "not to smoke pot while they are holding a cocktail in one hand and a cigarette in the other." True, the hypocrisy exists. But why should legalized marijuana?

Instead of speaking about psychotropic drugs, including tranquilizers—the subject on which she was asked to testify—Dr. Mead, 67, used the opportunity to air her views on the topic of legalized marijuana, and seemed to consider herself somewhat an expert on the subject. It seems a bit hasty to assume that marijuana "doesn't lead to the excesses of behavior that alcohol does, and it does not have the toxic effects of cigarettes," and "I think talk of marijuana leading to heroin use is sheer fabrication." Are these statements supported by extensive research? Surely if modern doctors, scientists, and the general public had linked cigarettes to cancer and alcohol to "excessive behavior" earlier, these "necessities" would have long since been outlawed, long before they became so much a part of our culture. Only recently has the problem of marijuana come into focus and have studies been conducted. Certainly such a controversial drug as marijuana warrants further tests before it can be legalized.

Dr. Mead stated that she tried marijuana once, but did not "find it something I need. But if I were young today I'm sure I would be using marijuana." But, if Dr. Mead did not "need" the drug, why would she now be using it? As yet, it has no proven beneficial use. Why should 16-year-olds choose to, and be allowed to, legally gamble with such a possibly harmful drug?

If then, Dr. Mead favors legalization, and would be using the mind-expanding drug, what comment does this make on our society? Is the escape of reality the ultimate goal? Certainly, overcrowding and the quickening pace of everyday life has added tensions to our modern world. But Dr. Mead has gone so far as to advocate the everyday use of pills, and marijuana, to relieve the unnecessary tensions and frustrations. Dependence on such drugs can only lead to dangerous self-deception. Every day, television offers children an escape from reality, into a world of never-never land. Why should we encourage and even legalize yet another reality-escaping mechanism?

Dr. Mead, come down to earth!

DJA

THE CHANGING STATUS OF *ADOLESCENTS* *IN THE* *MODERN WORLD*

If we examine human development, as the human species became established as the species we know today, one of the most interesting developments has been the changing lengths of the various portions of the life cycle, as the period of early maturation was extended and human beings attained greater longevity. Among these developments, the postponement of puberty is one of the most important. This postponement allowed a longer period in which children, untroubled by the urgencies of puberty, could devote themselves to mastering the increasingly complex human culture. Today, children are reaching puberty at an earlier age, and the roles of children, young people, and adults in the present-day world are rapidly changing.

MARGARET MEAD, PHD
Curator of Ethnology
The American Museum of Natural History
Adjunct Professor of Anthropology
Columbia University
New York



Many hundreds of thousands of years ago, human beings probably reached maturity at a much younger age, possibly as early as age nine or ten. The implications of such precociousness are found in *The Lord of the Flies*, which details the cruelty which may accompany the giving of power to young boys. Within such a context, we can better understand this crisis occuring at age five or six. Psychoanalysts call this the age of the Oedipus Complex, and it occurs in some form all over the world. Superficially, it seems to make sense for a child of this age to challenge his father, or for his father to respond with rage to this challenge. But, unlike earlier generations, when a six year old might have to wait, not ten years, but only two or three to achieve his full strength, this challenge to adults, today so premature, becomes more intelligible. For a mature 9 year old to challenge aging 20 year olds for the available supply of women is no more unintelligible than for young men of 20 to be restive under the control of men of 60.

During the course of the development of the human species—we do not know, and we may never know, just when or how—maturation was prolonged and a significant pause was introduced between the development which we now see at age six, and puberty. Psychoanalysts call this pause latency. It gave children a period of relative freedom in which they could learn all the basic things their society required them to learn—to hunt and fish, to build houses, and as civilization advanced, to read and write and figure, and learn to handle more and more complicated ideas. It gave the human race more time to explore the capabilities of the very powerful brain, a brain that has still not been used to anywhere near its full capacity. We can hypothesize that if any human or pre-human groups failed to develop this period of latency and learning, they would have been obliterated by those who did.*

We used to believe that primitive peoples were somehow inferior to ourselves, being less fully evolved, and reaching puberty earlier than modern civilized man. But we know today that not only were primitive people members of the same human species, without socially relevant differences from ourselves, but also that it is in civilization that young people are reaching puberty earlier and earlier. The age of puberty is dropping four months a decade, and has been doing so since the end of the last century.

This may be one of the most serious biological problems that will face mankind. We may have to develop ways to slow down maturation, if we are going to preserve this invaluable period of freedom to learn. As puberty occurs earlier, children are consequently growing taller earlier. One of the factors that is complicating the relationship between adults and young people in this country today is that seventh graders now look like college students. This distorts adult perceptions concerning their intellectual and physical maturity.

As we began to seriously study child development, some specialists found it useful to speak of the period of six-year-old crisis as a first adolescence, and puberty a second. This makes it possible to speak of a third or fourth or fifth adolescence, as longevity is increased and social conditions permit change and growth well into the adult years. Adolescence then becomes the name for the crises that occur between the periods of physical growth and the development of roles and choices within a given society.

Now that our focus is changing, we can give more attention to possible physical changes—in addition to menopause—which may trigger these social-psychological crises. European research workers have suggested that such a period occurs at about the age of 29 in women, for example.

As society becomes sufficiently complex to stimulate and provide for lifelong intellectual and emotional growth, it may be that everyone will die in some sense immature, with unrealized possibilities. The longer the life span, the more crises there will be, crucial points where individuals will want to change their careers, their mates, their ecological niches. Such a view of puberty, as the second adolescence, changes our understanding of what is happening to the young. If we are to understand the significance of puberty, we have to know where it stands, not only in relation to birth, but also in relation to death.

In very simple primitive societies, at the hunting and gathering stages, children have learned everything that they need to know to survive by the time they are six or seven. A few years later, they marry and function as full members of society. Puberty is not a crisis of choice and self appraisal for them, but simply the time to get married and become full members of society.

As society became more complex, it was impossible for six and seven year olds to either comprehend or master the physical and intellectual skills necessary to function in and manage social life. Today it is impossible for 14 and 15 year olds to do so. We have been building societies in which individuals need a longer period of preparation to understand the world in which they live. And while they are learning, they need protection and support. The crisis in American education today stems from our failure to prepare millions of children to function in a complex urban, rather than in a simpler rural society.

**For a fuller discussion of the possible mechanisms through which this evolutionary change may have occurred, see* "Totem and Taboo Reconsidered with Respect," *by Margaret Mead, in the* Bulletin of the Menninger Clinic, *27, No. 4 (July, 1963), 185-199.*

During the last two decades, however, as the demand for higher education has grown, we have also been forcing young people to marry early to prevent illegitimate births. When we abandoned the chaperonage of young people, we began substituting premature marriage as a way of dealing with the ethics of the situation. Yet, all our records show that marriages between young people in their teens are usually unstable and unsatisfactory, and that teenagers are unprepared for the responsibilities of parenthood. As a society, we may, of course, decide to deal with this matter by treating marriage, and possibly even parenthood, as part of higher education. Years ago, many eastern European Jewish boys were married at 14 or 15, but the young couple was completely supported by their parents, as the boy continued his studies. In many aristocracies, the children marry early, supported and surrounded by numerous tutors and retainers.

We seem very close to deciding that mating should become a part of higher education, as we build coeducational dormitories and remove more and more paricta1 restrictions. But if we are to make parenthood a part of higher education, then it will be necessary to provide a great deal of auxiliary help for the young parents, instead of leaving them, as we do today, to struggle with the economic, as well as the emotional problems of parenthood. If we decide to do this, we should include the bearing of two children within the educational period necessary to prepare for a professional career, and provide nursery schools and baby sitters. The tendency of young women today to view the period of motherhood as something to be completed as soon as possible, combined with the demand for smaller families in response to the population explosion, may aid in developing educational institutions of this sort.

We will have to seriously examine the means that would be used and the consequences incurred when intervening in this process of earlier and earlier puberty. We may decide that the latency period has been, and still is, invaluable, and that it should be further extended physiologically, rather than be allowed to contract. Or we may decide that if mating and parenthood are sufficiently protected so that they do not place too much of a strain on the young while they are learning, we can extend latency educationally, rather than physiologically. This is what the Russians have done, by postponing an active concern with sex so that their young people have enough time to fully complete their education.

We must, however, also study the present world. This period is unique. The technological changes which are characteristic of today's world carry with them tremendous ethical implications. The bomb has changed warfare from an event that kills and maims millions, to a political event which can destroy the whole of mankind. We have become the keepers of the future, not only of our own country and continent, but of the whole world. This has profoundly affected our young people. They, far more fully than we ever can, now appreciate the significance of these changes.

Many commentators have described the present youthful unrest as part of the normal adolescent rebellion, complicated in the United States by affluence, permissiveness, the draft, civil rights, and the war in Viet Nam. I do not agree. True, in every society there are adolescents, and society has to come to terms with their burgeoning sense of themselves. Some societies have been stern, and some lenient. The only connection the present unrest has with adolescence is that the present generation gap is occurring at, or soon after, the onset of puberty, as this is the period when young people usually leave home for school or work and become sensitive to what has happened since World War II. World War II was the breaking point. Since then, change has come so fast that adults have not had time to assimilate the knowledge and teach it to the young. Five years ago, the realization of this gap had reached the colleges; today it has reached the high schools, and so coincides more and more closely with the normal generation conflict that arises in puberty. But it is not due to puberty; it is not simply adolescent rebellion. It is something very different and far more serious.

Throughout recorded history, there have been changes which have profoundly altered the relationship between generations. But the changes have come slowly; the adults had time to learn how to handle the new inventions and to teach their children how to use them. Today, there are so many changes occurring all over the world that adults cannot keep up with them. Young people—more mature, and in many ways better educated than any previous generation—realize that there are no adults anywhere who know how to manage the present world. Since none of them grew up within it, the adults who grew up before World War II speak what is essentially a different mother tongue than the young people who grew up afterwards. What understanding our generation has of space and world-wide TV, of the implications of the bomb, the population explosion, and the universal threat of pollution is like the understanding one has of a second language, learned as an adult. For the children, all this is their mother tongue. Where we counted to 500 by fives: "5, 10, 15, 20 . . . 500 and all around my base are caught," they count 10, 9, 8, 7, 6 . . . . We are immigrants from another time, instead of another continent, trying to live in a world we never knew as children.

This is one reason that education is breaking down.

Previously schools worked, no matter how archaic they were, as long as the teachers themselves had learned in the same ways that they were expected to teach. But today, there are no teachers who learned the material that they must now teach their pupils: mathematics, geography, ethics, and biology have changed dramatically within the past few years. The world has been transformed by a generation who was not given time to fully assimilate it. This is why the young people of today will never understand the Depression. Only it isn't the Depression; it is the radical change in every part of today's world, in every country, at every level of technological development.

One morning at the Maryland Institute of Design, a student commented on what I had just said about the Manus people of New Guinea skipping 2,000 years and coming into the modern world. He raised the perfectly logical point that they had somewhere to go, models of what they wanted to be. But the young people in highly developed countries like the United States, Western Europe, the Soviet Union, and Japan, are the first generation on the edge of the greatest technological change the world has ever known. They have no models. They have no blueprints. The only models they have are from science fiction, from the prophecies and laments of those who have never known today's world as the young know it. We criticize them for having no program, because in the past, the radical reformer or revolutionary adults could present the radical young with programs. Today, when they search for adult heroes, the young find them in revolutionaries who died early, or in anarchists, notable for their lack of program.

It is only since the 1940's that there has been any widespread acceptance of the problems peculiar to puberty, and the conflicts between parents and children which are characteristic of puberty. We then began popularizing what was known about adolescence, telling young people what they were going through, and just how awful it was. Since that time, there has been an enormous popularization, and vulgarization, of the scientific findings on human growth and development, from the proper behavior at two months to the proper forms of musical appreciation or dress or riots at sixteen. We have been categorizing young people, putting them in narrow age bands, labeling them—sociologically, psychologically, psychiatrically, anthropologically—talking about their search for identity, their apathy, their role diffusion. The mass media have popularized prescriptions for the whole country, with careful notes on how hippies differ from yippies, or diggers. In the 1920s, girls ran away to Greenwich Village, but their families hushed it up; there was no mass media exposure which led dozens of other girls, with no natural bent for Bohemia, to follow them because it was the thing to do. Today, hundreds of thousands of youngsters are drawn into single styles propagated by the mass media.

Today's children have been raised by mass media; they live in a world that is made possible by the mass media, binding all young people everywhere in the world together. But they are trying to build something different. They plead for greater person-to-person intimacy, for love, for humanity. They want real, significant contact with others, not merely contact on the TV screen, or school-closed TV; they want meaningful participation.

The young people's demands for more participation is related, in part, to the demands of any previously excluded group—ethnic minorities, religious minorities, women, the retired—for a voice in the society. They are asking to be recognized as those who have a unique stake and a unique contribution to make. And significantly, it is not the children of excluded groups, but the children of the most established, those closest to the seats of power, who are clamoring for a voice *Now*, not 20 years from now. They are unwilling to wait. They watch and do not trust their elders who are fumbling in a world they do not understand. Until now, it was possible to say, "Wait, wait, in 20 years you can have it your way." The answer of the young today is, "We are not sure there will be a world in which to have our way, unless you listen to us now."

But the facts of physical growth and maturation are still there. Stubborn facts: Young people at puberty have all the characteristics that young people at puberty have ever had. They are faced with their relationships to themselves, to the opposite sex, and to their parents, just as they always have been. In addition, they carry this new burden. They are the only ones to have grown up as natives of this new post World War II world. They desperately need our help and protection, our technical and political know-how, outdated as it is, and we as desperately need their questions, and their challenges.

An edited transcription of an address delivered at the 1968 Fall Symposium on "The Twentieth Century Adolescent," November 13, 1968. An amplification of this discussion on the generation gap will be published by the Natural History Press as Culture and Commitment, *The Man and Nature Lectures of The American Museum of Natural History Lectures, Series V.*

Cephaloridine Dosage in Infants and Children

STUART H. WALKER, MD
Associate Professor of Pediatrics
University of Maryland School of Medicine

VICTORIA T. MAISOG, MD
Fellow in Pediatrics
Mercy Hospital

Cephaloridine, a semi-synthetic derivative of cephalosporin C, possesses the same range of antibacterial effectiveness as other cephalosporins, but produces less tissue reaction when injected intramuscularly, is less serum bound, possesses a longer serum half-life, and appears to penetrate the bacterial cell more rapidly.[1-3] Cephaloridine has been demonstrated to be regularly effective in the treatment of gram-positive coccal infections, and less regularly effective in the treatment of gram-negative bacillary infections.[4,5] Toxic reactions have not been reported frequently, but occasional instances of hypersensitivity, and possible nephrotoxicity and hepatotoxicity have been recorded.[6-8]

The study reported below was designed to evaluate the effectiveness and toxicity of this agent at varying serum levels, and at varying dosage schedules in infants and children.

Material and Methods

During the period from April 1966 to August 1967, 67 patients who were admitted to the Pediatric Service at Mercy Hospital in Baltimore were entered into this study. All were suffering from an infectious disease which was presumed to be due to an organism sensitive to cephaloridine. An additional 13 patients were treated expectantly because of the likelihood of systemic infection. Cephaloridine was administered in two dosage schedules: 50mg/kg/day to 10 patients, and 100mg/kg/day to 39 patients. The dosage was given intramuscularly or intravenously in equally divided doses at six-hour intervals during the first part of the study. Later, it was administered in a dosage of 200mg/kg/day to 15 patients, and to three patients at 400mg and 600mg/kg/day. Additional therapy was provided as indicated, and did not vary significantly from usual management procedures. Additional antibiotics were not given, except when cephaloridine failed to control the infectious disease.

From the isolation of a pathogenic organism from cultures of blood, cerebrospinal fluid, urine, or needle aspirate, it was determined that 37 patients had specific infection. Of these, 21 had systemic infections, while infections in 16 were superficial or localized. Disease was discovered in 30 patients, presumably with an infection of a cephaloridine sensitive bacterium. However, no pathogenic organism was directly isolated.

Cephaloridine was administered intramuscularly, until complete resolution of the signs and symptoms of disease. A complete blood count, urinalysis, serum glutamic oxalacetic transaminase (SGOT) determination, and blood urea nitrogen (BUN) determination were performed on all patients at the time of initial therapy. Afterwards, the tests were given at weekly intervals, and finally, at the termination of therapy. The minimum course of therapy was four days.

Demonstration of the presence of infection in each patient was attempted by culture of blood, urine, stool, cerebrospinal fluid, nasopharyngeal secretion, or available exudate at the site of infection. Pulmonary infections were evaluated by percutaneous lung aspiration. Only those patients from whom pathogenic organisms were isolated by blood or aspiration cultures were considered definitely to have infection. Culture of appropriate material was repeated periodically to demonstrate eradication of infection.

Specimens for assay of the cephaloridine content of the serum of all treated patients were obtained at various times after the initiation of therapy, and at various intervals after the most recent dose. In appropriate patients, specimens were obtained for assay of the cephaloridine content of pleural exudate and cerebrospinal fluid. All assays were performed by the Lilly Laboratories for Clinical Research by the cup-plate method using *Sarcina lutea* as the test organism.

The sensitivity of all pathogenic isolates was initially determined by the single disc-agar plate method. The sensitivity of H.influenzae isolates from patients with meningitis was subsequently determined by the tube dilution method.

Results

After detection, staphylococci, pneumococci, and group A betahemolytic streptococci were eradicated in all the patients who were treated, and all such patients recovered. These patients included five with staphylococcal pneumonia, three with staphylococcal sepsis, three with pneumococcal pneumonia, two with pneumococcal meningitis, one with alpha-hemolytic streptococcal meningitis, and one with beta-hemolytic streptococcal sepsis. One patient with sepsis, due to Salmonella Heidelberg, relapsed after five days of therapy, but the organism was eradicated after ten days of additional treatment. Two other patients with mixed infections in the urinary tract—one a combination of *P.mirabilis* and *E.coli,* and the other a combination of *S.aureus* and *E.coli*—responded satisfactorily with eradication of infection.

Three patients with H.influenzal meningitis failed to respond adequately to cephaloridine in dosages ranging from 100 to 600mg/kg/day, although the organisms isolated were inhibited in diluted inocula in vitro (tube dilution method) by concentrations of 0.8μg, 3.2μg, and 7.5μg/ml. Each patient demonstrated a rising temperature, increasing depression of perceptual and motor abilities, and the persistence of H.influenzae in cerebrospinal fluid cultures after an initial 48-hour period of improvement. Cephaloridine was discontinued and ampicillin was instituted with substantial improvement in each.

All of the isolated strains of pneumococci, streptococci, staphylococci, P.mirabilis, and E.coli were considered to be sensitive by the single-disc-agar plate method.

Among 30 patients with infectious diseases of unknown origin, all but one recovered without incident following treatment with cephaloridine. This one patient had interstitial pneumonitis in association with progressive respiratory failure due to Werdnig-Hoffman paralysis. Thirteen patients, chiefly newborns, were treated expectantly because of the increased likelihood of bacterial infection. Infection did not occur in any patient so managed.

No significant toxic reaction to cephaloridine was detected. A transient increase (a rise greater than 20 units) in the SGOT concentration occurred in three patients, one of whom was receiving cephaloridine in a dosage of 400mg/kg/day. No other evidences of hepatic injury appeared in these patients, nor in any others. An elevation of the

BUN concentration occurred in one infant with H.influenzal pneumonia, but returned to normal when therapy was continued. One patient complained of pain and demonstrated slight inflammation where the drug had been injected intramuscularly. The transient chemical alterations detected were not correlated with the dosage administered.

The analyses of serum for cephaloridine content, after varying the dosage at six-hour intervals, revealed a direct correlation between dosage and serum concentration in older infants and children. In newborns, however, serum concentrations were extremely variable (Fig. 1). In some newborns, high serum concentrations persisted for three to four hours, and were as high, or higher than the peak levels achieved in older infants and children at twice the dosage. In the majority, serum concentrations were in the range of 10-20μg/ml throughout the six-hour period, following a dosage of 50mg/kg/day administered intramuscularly. In two instances, the serum concentration was 8 and 16μg/ml six hours after injection.

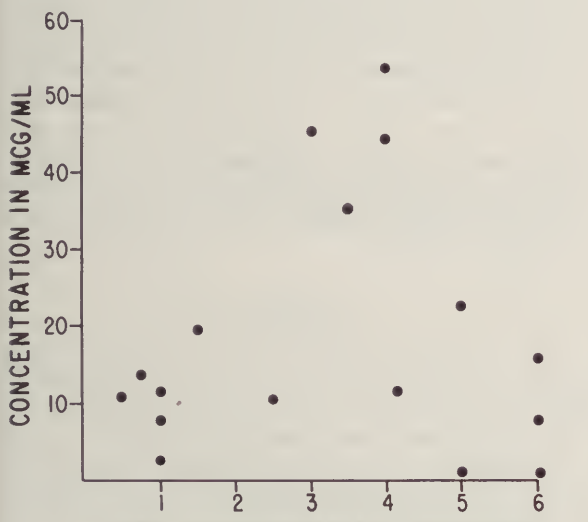


FIGURE I. SERUM CONCENTRATION OF CEPHALORIDINE IN NEWBORNS GIVEN 50mg/Kg/24 HOURS INTRAMUSCULARLY.

In infants of four weeks to two years of age, who were given cephaloridine intramuscularly in a dosage of 100mg/kg/day, peak serum concentrations were reached within the first two hours. This was approximately 30μg/ml (Fig. 2). The first half-life of the serum concentration in these patients was approximately three hours; and during the sixth hour concentrations were consistently less than 4.0μg/ml. At this dosage, the average concentration from the second to the sixth hour was less than 10μg/ml.

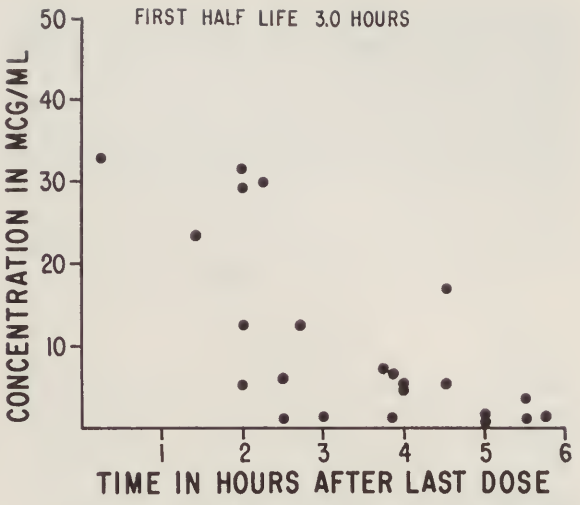


FIGURE 2. SERUM CONCENTRATION OF CEPHALORIDINE IN INFANTS (4 WEEKS-2 YEARS) GIVEN 100 mg/Kg/24 HOURS INTRAMUSCULARLY.

Similarly, when children over two years of age were given cephaloridine intramuscularly in a dosage of 100mg/kg/days, peak serum concentrations were achieved in the first 2½ hours, which was approximately 30μg/ml (Fig. 3). During this period, however, the range of concentration was wide—4.0 to 47μg/ml. The first half-life of the serum concentration in these patients was approximately 2.2 hours; during the sixth hour, concentrations were consistently less than 6.0μg/ml.

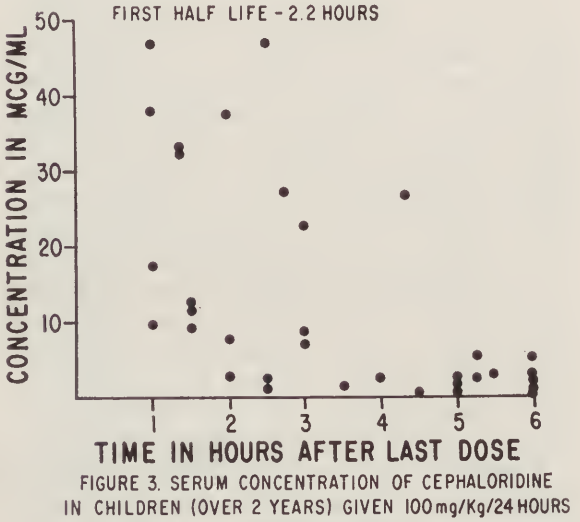


FIGURE 3. SERUM CONCENTRATION OF CEPHALORIDINE IN CHILDREN (OVER 2 YEARS) GIVEN 100 mg/Kg/24 HOURS INTRAMUSCULARLY.

Peak serum concentrations were achieved within the first four hours when infants of four weeks to two years of age were given cephaloridine intra-

muscularly in a dosage of 200mg/kg/day. This was approximately 50μg/ml (Fig. 4). The first half-life of the serum concentration in these patients was approximately 2.1 hours; during the sixth hour, concentrations were consistently less than 6.0μg/ml. At this dosage, the average concentration from the second to the sixth hour was 19.2μg/ml.

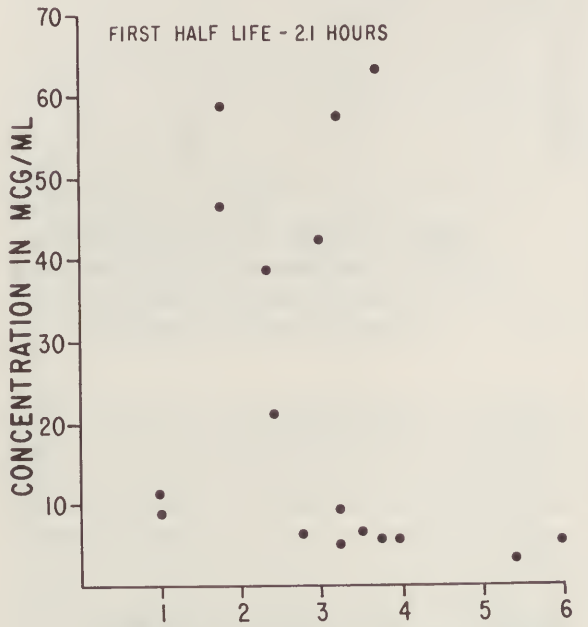


FIGURE 4. SERUM CONCENTRATION OF CEPHALORIDINE IN INFANTS (4 WEEKS-2 YEARS) GIVEN 200 mg/Kg/24 HOURS INTRAMUSCULARLY.

There was little difference between the average serum concentration achieved and the half-life of this concentration in infants four weeks to two years of age, and in children over two years of age when given a dosage of 100mg/kg/day (Fig. 5). In both groups, the average serum concentration was highest within the first hour after intramuscular injection. It fell rapidly to less than 5μg/ml at the end of four hours, and remained at lower levels thereafter.

After injection, with multiple doses at six-hour intervals, there was no evidence of accumulation of cephaloridine. Prior to assay, patients who had several days of therapy showed no consistent elevation of cephaloridine serum content above that detected in patients who had received but one dose.

Examination of the cephaloridine content of pleural exudate obtained from a patient with staphylococcal pneumonia revealed concentrations of 8.0μg, 12.5μg, and 14.4μg/ml between 150 and 180 minutes after dosing at 200mg/kg/day. These concentrations are comparable to those found in the serum under similar conditions. Assay of the cephaloridine content of the cerebrospinal fluid in three

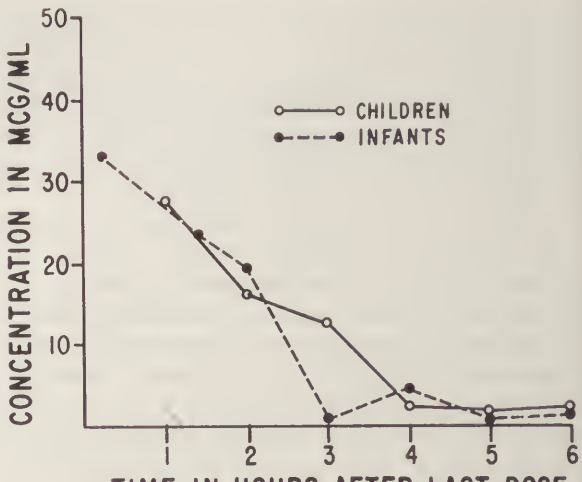


FIGURE 5. COMPARISON OF SERUM CONCENTRATIONS OF CEPHALORIDINE IN INFANTS AND CHILDREN GIVEN 100 mg/Kg/24 HOURS INTRAMUSCULARLY.

patients who did not have meningitis revealed concentrations of less than 1.0μg/ml in each, in the presence of serum concentrations ranging from 11.4 to 38.7μg/ml. Cerebrospinal fluid concentrations during the second, third, and fourth days of therapy of two patients with bacterial meningitis ranged from 13.6 to 104.0μg/ml, when serum concentrations ranged from 41.8 to 108.2μg/ml. On the fifth, sixth, and ninth day of resolving bacterial meningitis, cerebrospinal fluid concentrations ranged from 0.98 to 5.2μg/ml when serum concentrations ranged from 5.5 to 24.4μg/ml.

Discussion

In this study, cephaloridine was consistently effective in the management of proven gram-positive coccal infections and infections presumably due to such agents. It was inadequately effective in the management of Hemophilus influenzal meningitis. In vitro studies have demonstrated that group A beta-hemolytic streptococci and pneumcocci are regularly killed by cephaloridine concentrations of less than 1.0μg/ml.[1,9] Some strains of Hemophilus influenza are resistant to concentrations in excess of 25μg/ml.[9,10] Kislak, et al[1] and Steigbigel, et al[5] have demonstrated that inoculum size is a major determinant of sensitivity to cephaloridine. It is likely that heavy inocula at the site of H.infleunzal meningitis impaired the effectiveness of cephaloridine, even though the organisms were demonstrated to be sensitive in vitro in diluted inocula to the concentrations achieved.

The serum concentrations achieved by dosage at 100mg/kg/day were continuously in excess of those required for bactericidal effect against gram-positive cocci throughout the six-hour period following dos-

ing. However, 30% of strains of *E.coli*, 20% of strains of *P.mirabilis*, and the majority of strains of *Klebsiella* are resistant to 12.5μg/ml. of cephaloridine in undiluted inocula.[5,9] (All other strains of Proteus and all Pseudomonads are completely resistant.) Even the 200mg/kg/day dosage in infants did not regularly provide an average serum concentration greater than 12.5μg/ml. during the first four hours after dosing; although it did so more frequently than did the 100mg/kg/day dosage. Between four and six hours after dosing, serum levels in both infants and children usually were not greater than 6μg/ml at either the 100 or 200mg/kg/day dosage. Cephaloridine administered in these dosage schedules should not be relied upon in the management of systemic gram-negative enteric bacillary infections.

A dosage of 50mg/kg/day often produced serum concentrations in newborns as high as did a 100, or even 200mg/kg/day dosage in older infants. In newborns, the average serum concentration between four and six hours after injection at this dosage was approximately 10μg/ml. Although only a small number of patients was studied, it seems reasonable to presume that the expected decrease in renal excretion of cephaloridine in newborns does permit the maintenance of adequate serum concentrations at lower dosage and for longer periods than in older infants and children.

The serum concentrations achieved in the older infants and children of the present study are similar to those detected in a similarly-treated pediatric population by Flux, et al.[11] They are comparable to those achieved at similar dosage in adults.[4,9] Peak concentrations in adults have been reported occurring between 30 and 60 minutes with a half-life between 48 and 90 minutes.[1,6] The longer half-life detected in these infants and children may reflect some decrease in renal excretion persisting beyond the newborn-period. This is consistent with the extended half-life detected in aged patients and those with elevated BUN concentrations by Apicella, et al.[14]

Penetration of cephaloridine into pleural and cerebrospinal fluid was excellent in the presence of inflammation. Concentrations at these sites in patients with empyema and early meningitis were between 30% and 100% of simultaneous serum levels. In the absence of inflammation, however, cerebrospinal fluid concentration was between 1% and 10% of serum concentration. During the early recovery from meningitis, cerebrospinal fluid concentration was approximately 20% of serum concentration. This pattern is typical of the pattern of the penetration of the pharmacologically-similar penicillin molecule in body fluids.[12]

No significant toxicity attributable to cephaloridine was detected in this study, nor in the study of pediatric patients by Flux.[11] Skin rash has been reported as an indication of hypersensitivity in 1% to 4% of various treated groups.[4,7] One study detected frequently transient elevations of SGOT concentration and of prothronbin time.[7] However, most investigators have failed to detect any evidence of hepatotoxicity. Renal tubular necrosis in rats has occurred after large doses of cephaloridine, and nephrotoxicity has been suspected in four reported adult patients.[2,6,7,8,13]

Summary

Eighty newborns, infants, and children were treated with cephaloridine administered intramuscularly at varying dosages. Adequate serum concentrations and clinical effectiveness in the treatment of gram-positive coccal infections were achieved in older infants and children at a dosage of 100mg/kg/day administered intramuscularly at six-hour intervals. Dosage of 200mg/kg/day was well tolerated in all of the infants and children so treated and produced serum concentrations approximately twice as great as a dosage of 100mg/kg/day. In newborns, a dosage of 50mg/kg/day resulted in serum concentrations comparable to those achieved at twice the dosage in the older infants and children. No significant toxicity was detected at any dosage level. (Table 1.)

TABLE 1—Therapeutic effect of cephaloridine in eighty infants and children.

DIAGNOSIS	Number of Patients	Cure	Relapse	Failure
PROVEN INFECTION (37)				
SYSTEMIC (21)				
Staphylococcus	8	8	0	0
Pneumococcus	5	5	0	0
Streptococcus	2	2	0	0
H. influenza	5	2	0	3
Salmonella (Heidelberg)	1	0	1	0
SUPERFICIAL OR LOCALIZED (16)				
Staphylococcal	10	10	0	0
Streptococcal	2	2	0	0
Mixed Infections	4	4	0	0
DISEASE OF UNKNOWN ETIOLOGY (30)				
Pneumonia	20	19	0	1
Adenitis	3	3	0	0
Enteritis	2	2	0	0
Carditis	1	1	0	0
Cellulitis	1	1	0	0
Periappendicitis and salpingitis	1	1	0	0
Otitis media	1	1	0	0
Urinary tract infection	1	1	0	0
PROPHYLAXIS (13)				
Premature rupture of membranes	5	5	0	0
Respiratory distress syndrome	2	2	0	0
Hydrocarbon pneumonitis	2	2	0	0
Miscellaneous	4	4	0	0
TOTAL:	80	75	1	4

(See page 82 for a list of references)



Sudden Unexpected Death in Infants

GILBERT E. CORRIGAN, MD, PhD
Former Research Fellow in Forensic Pathology
Assistant Professor of Pathology
University of Texas—Medical Branch
Galveston, Texas

with a preface by RUSSELL S. FISHER, MD
Chief Medical Examiner for the State of Maryland

Sudden unexpected death in infancy, or crib death, as it is frequently called, is responsible for nearly half of all deaths in infants between the ages of 3 weeks and 12 months. Although the examination of cytological specimens from the tissues and organs studied at autopsy is not a routine procedure, such an examination is made in cases of sudden unexpected death (SUD), since the results of such histological studies are often equivocal and debatable.[1]

Preface

The following table shows the statistics for incidences of crib death in Maryland in 1967.

Age	Not SDII	SDII	Total
Under 2 months	61	42	103
2-3 months	25	44	69
3-4 months	21	31	52
4-6 months	28	33	61
6-12 months	59	14	73
	194	164	358

The cases shown in the "SDII" column include infants who, prior to death, had no known significant congenital defects and were not recognizably suffering from any major disease, or did not present any serious growth or developmental deficiencies. Seemingly healthy, infants such as these are either found dead in their crib or, if under observation, die within minutes after the onset of signs of respiratory or circulatory distress. Nearly all become Medical Examiner's cases, and in the absence of a recognizable cause of death, an autopsy is performed. In the event that the post-mortem examination reveals unsuspected serious congenital anomaly or sufficient

pathological findings to explain the death, the case is relegated to the "Not SDII" category, although in some of these cases, the immediate cause of death must be the same as in the SDII cases. Also included in the SDII category are those cases that exhibit isolated acute otitis media, focal scanty bronchopneumonia, or other respiratory conditions not accompanied by gross disease, and not ordinarily accepted as a cause of death.

The theories offered to explain SDII are many, ranging from status thymicolymphatius, allergy to cow's milk, smothering in the bed clothes, postural asphyxia suffered by simply resting the face on a pillow, laryngeal spasm due to a calcium metabolism deficiency caused by a lack of vitamin D in the mother during her pregnancy, secret homicidal asphyxia due to maternal mental illness, asphyxia due to mucosal swelling with occlusion of the nasal airway in infants who have not learned to mouth-breathe when necessary, to overwhelming bacterial or viral infection so acute that the body shows no pathological signs of its presence in the short interval between onset and death. However, none of these theories is adequate to solve the problem of why these infants die. The following study, reported by Dr. Corrigan, presents additional evidence indicating that infection somehow leads to the sudden death of healthy infants.

Introduction

The cytological examination method is limited both by the lack of standards for determining the normal cytology of the organs of the human infant, and by the autolysis present in the smears and imprints obtained. However, the advantage of examining the specimens lies in the extension of the morphological parameters of the tissues and organs. A smear of the lining mucosa of an organ allows the examination of a greater number of mucosal cells than does a cut section. It also permits a more facile determination of the nature of the cells present. In addition, the inflammatory and reactive cells present on smears are more readily recognized and typed than are those in histological section. It is common knowledge that in the evaluation of certain types of neoplasms, a properly fixed and stained imprint is of great diagnostic value.

The following study was undertaken not to establish absolute standards of reference, but rather to uncover reactive areas which are elusive in routine histology and so to promote new lines of morphological research. "We are confronted with a problem which demands the exploration of every avenue"—Lester Adelson.[1]

Materials and Methods

During a six-month period, cytological specimens were prepared at the time of autopsy from 25 infants (two controls) whose deaths were investigated by the Medical Examiner's office of Maryland. Wooden applicator sticks were used to take smears of the mucous membranes of the conjunctiva, larynx, trachea, and bronchi. Imprints of the lungs, tonsils, thymus, spleen, kidneys, salivary glands, lymph nodes (thoracic and abdominal), caecum, leptomeninges, and bone marrow were made by direct application of the tissue to a clean slide. In addition, smears were made of the cerebrospinal fluid and the blood. The specimens were fixed immediately in 95% methanol. They were stained with Giemsa stain (1%) overnight and examined microscopically under ordinary light, both after preparation, and as composite groups. A latter series (ten cases) stained with the Papanicolau technique rendered results similar to those stained with Giemsa, but the results are not reported in this study.

The infants studied were all free from major disease prior to death and had few significant alarming symptoms. They were developing normally for their age and were free from obvious nutritional deficiencies. Those with major disease (ie—bacterial pneumonia) and with obvious congenital malformations at the time of autopsy were excluded from the study. Control cases were limited in number; an infant with traumatic abdominal hemorrhage and an infant with head injuries were used in the study. Most of the infants were two-to-four-months-old; none were older than eight months. Race and sex of the infants studied were distributed relatively evenly.[2]

These cases all exhibited peripheral cyanosis of the extremities, variable patterns of internal and external petechiae, expanded lungs of increased consistency, well developed thymic glands, and flattened adrenal glands. All were classified histologically by local department standards as having interstitial pneumonia. This latter diagnosis includes moderate pulmonary congestion and edema, small lymphocytic infiltrates about some major bronchi, thickening of the alveolar septae, and moderate to advanced infiltration of the septae with medium-sized lymphocytes and occasional polymorphonuclear neutrophils. In approximately half of the cases, cultures were made of the conjunctiva.

Results

The results from the examination of over 500 slides are best considered generally rather than by a detailed slide-by-slide review.

Acute and chronic inflammatory cell aggregates (polymorphonuclear neutrophils and lymphocytes) were present in practically all (20/23) of the smears of the respiratory tract. There were three exceptions in which no inflammatory cells were present. Interestingly, chronic inflammatory cells (small lymphocytes) were found in the tracheal smears of the two

control cases, but the remainder of specimens from the respiratory tract of these two infants were free of inflammation. There was a wide range of involvement.

The meninges, cerebrospinal fluid, and bladder mucosa were free of abnormalities, except for one case which exhibited increased numbers of lymphocytes in the meninges. The lymphopoietic tissues (tonsils, thymus, lymph nodes, spleen and caecum) were normal; the reticuloendothelial cells were free from bacteria and other organisms. Imprints of the salivary glands were characterized by the presence of bacteria on the surface and in the cytoplasm of large ductular cells. This phenomenon occurred in all specimens, but was variable both in the quantity of bacteria present and the number of cells affected.

The examination of the blood and myeloid tissues was restricted by post-mortem autolysis. The red cell series was normal; the myeloid series had an apparent increase in the number of eosinophils in the bone marrow. Autolysis of the materials studied prevented the analysis of this apparent increase. In addition, eosinophils were noted to be uncommon in the organ specimens studied, and in the conjunctiva.

Inflammatory cells, with or without engulfed bacteria, were present in all the conjunctival smears. The cells were almost exclusively polymorphonuclear neutrophils. Generally, a few lymphocytes were also present. Eosinophils, basophils, and plasma cells were absent. Conjunctival cultures revealed micrococci, pneumococci, H. influenza, and streptococci. However, the results of these cultures did not correspond with the results of the blood cultures.

Discussion

The incidence of acute and chronic inflammatory cells in nearly all of the samples of the respiratory system presents a higher index of inflammation than previously reported.[3] This is probably due to the larger number of samples made available through the use of cytology. The actual presence of infection cannot be extrapolated from these findings, however, for the respiratory system is known to bear a moderate reactive inflammation to both infectious and noninfectious toxic stimuli whose locus is extrarespiratory.

Although Muller [4] described changes in the lymphoid tissues of the spleen, tonsils, and lymph nodes, his findings have not been verified by others.[2] Nor does the present cytological examination of the lymphoid (reticuloendothelial) system bear any significant deviations from normal imprint lymphocytic populations. Indeed, the uniformity of these smears and imprints of the lymphoid tissues was a characteristic of the study.

The post-mortem invasion of the salivary ducts by bacterial organisms is a well established phenomenon. The presence of bacteria on the surface and in the cytoplasm of the large ductular cells of the salivary glands was thus considered a post-mortem artifact. It is possible, however, that this is an indication of a true ante-mortem bacterial infestation which was not sufficiently advanced to elicit a tissue response. Sialadentitis has been reported to occur in the SUD complex.[1] Interestingly, Bark and Perzik [5] have recently suggested that sensitization to infected salivary tissues may be a trigger mechanism for auto-immune phenomena.

The inflammatory cells (polymorphonuclear neutrophils) present in the smears of the conjunctival sacs are interesting, since they apparently always occur in such cases. There are few morphological entities in the SUD complex which have such a high incidence of occurrence. But the problem lies in the fact that while polymorphonuclear exudates of the conjunctiva are characteristically a result of bacterial infection, viral and physical-chemical attacks may produce similar exudates.[6]

Since this is a screening study that attempts to open new avenues of morphological study, the ocular manifestations of SUD should also be examined. In this light, the author sectioned a few eyes from infants with this syndrome but has been unable to verify any uveitis or other significant pathological changes in the eye. Examination of a larger series of specimens by a more competent observer is desirable.[7]

It is unfortunate that the study of the blood and bone marrow of these infants is so hampered by post-mortem autolysis. Stowens [8] has found that the number of eosinophils in the tissues is diminished; his observation has been supported in this study. Obviously, a well controlled study of the eosinophils of the blood, bone marrow and tissues of these infants is necessary (if it is possible to accomplish), if more conclusive evidence is to be obtained.

The absence of viral inclusions, giant cells, and other signs of viral activity in this series substantiates the known paucity of such findings on routine histological sections, and is in agreement with the low rates of viral isolation in infants dying from SUD.

Summary

This survey has demonstrated cytological changes only in the conjunctiva, salivary glands, and the respiratory system. Their relationship to the inflammatory response is also briefly discussed. It has added further evidence that there is a derangement of the eosinophils in infants dying from SUD. It prompts either a belief in the lethality of "minor" infections, or in the assumption of a "non-morphological" dysfunction of homeostatic mechanisms. Proof of this lies in the hands of histochemists, enzymologists, immunologists, neurochemists, and other molecular biologists.

(See page 82 for a list of references)

Season and the Onset of Acute Childhood Leukemia

F. ROBERT FEKETY, JR., MD
Associate Professor of Internal Medicine
Department of Internal Medicine
University of Michigan Medical School

JAMES J. H. CAREY, MD
Department of Medicine
The Johns Hopkins School of Medicine

The hospital records of 96 children with leukemia seen at The Johns Hopkins Hospital were reviewed to determine whether there was any seasonal variation in the onset of the disease. By date of diagnosis, there was an excess of cases from June to September. By date of clinical onset, there was an excess of cases from May to August. Various artifactual causes of the phenomenon were considered, but were not supported. The seasonal variation was most prominent in children living in the Greater Baltimore Area, in Caucasians, in girls, in children with acute lymphocytic or stem-cell types of leukemia, and children whose parents were less than 35 years old.

Old age, the white race, the male sex, higher incomes, urban residence, the Jewish religion, and better access to diagnostic services have been associated with relatively high rates of leukemia. Exposure to radiation has been implicated in leukemogenesis in several different kinds of studies and particularly with myelogenous leukemia. Acute leukemia is primarily a disease of children and young adults, and leukemia is the most common childhood neoplasm. Lymphocytic or stem-cell leukemia are the most common types in children. The peak incidence of leukemia in white children is between the ages of four and six; this age-associated peak is not seen in Negro children, in whom rates are much lower. Higher rates are found in association with mongolism, and with advancing maternal age.[1]

Space-time aggregations of childhood leukemia (clusters) have been reported, and in one community has been associated with a high incidence of congenital heart disease, and with a benign rheumatic-like illness.[2] Such clusters require better statistical methods than are now available for interpretation.

These epidemiological observations have encouraged speculation that acute leukemia, in many cases, may be a disease caused by an infectious agent. The recent demonstration of virus-like particles of still uncertain significance in the blood or bone marrow of patients with leukemia, or allied conditions, has greatly increased interest in this hypothesis.[3] Of great interest in this context are several reports suggesting that leukemia in children varies in the frequency of its onset according to season.[4-8] However, these studies have yielded varying results. Some have shown a preponderance of cases beginning in the winter and early spring; [4, 5] others have shown an excess in the summer; [6-8] and still others have shown no seasonal effects.[9-12] No study showing a preponderance of cases in the fall has yet been reported. The possibility of artifacts is inherent in most of these reports. Some suffer from small numbers, from bias in the selection of cases, or from using death certificates as the source of information about the onset of the disease. In many, the date of diagnosis is taken as the date of onset of the disease, since the earlier manifestations of the disease were deemed too difficult to date precisely.

Because of such variables leading to difficulties in interpretation, we decided to review the detailed records of patients admitted to the hospital with leukemia to see whether we could add new understanding to the possible seasonal variations in the onset of leukemia in children.

Methods

Only leukemic patients less than 20 years old when admitted to The Johns Hopkins Hospital between 1950 and 1962 were studied; 107 patients were in this category. No records were obtainable for 11 (10.2%) of the patients. Our efforts to locate them have led us to conclude that these records are lost or misfiled, and are not being used in any other study of leukemia. The remaining 96 patients comprise this retrospective study. The hospital records of these patients were reviewed, and the diagnosis of leukemia was considered adequately documented by blood, bone marrow, or tissue studies, and by clinical course in every instance.

After careful review of the chart for clinical and demographic data, four dates were determined for each patient. First, *the month of diagnosis,* which was readily ascertained in all patients. Second, *the month of death,* which was not available in 31 instances. The reason for this is that many patients returned to their homes or other hospitals after diagnosis and initial therapy here, and were lost to recorded follow-up. Our analysis, therefore, is probably filled with cases having a relatively rapid course, although the cases lost were distributed evenly throughout the year (according to date of diagnosis). The third date, *the month of clinical onset,* is probably the most important one, since it represented the earliest date at which definite evidence of the disease was present. It should be emphasized that this term is not meant to imply the date at which the disease began. Few criteria used for assigning this date can be listed. The month in which definite evidence of the disease was most likely present was selected on the basis of all the available evidence. In most cases, the clinical onset of the disease was sudden, and the first sign of definite illness was followed by the diagnosis of the disease within a few weeks. In a few instances, anemia had been documented, but had defied diagnosis for several months. The earliest month of definite anemia in these patients was chosen as the month of clinical onset. The same can be said for hepatosplenomegaly in a few cases. The month chosen for the time of clinical onset was the first date at which objective abnormalities, attributable to leukemia, were documented. In 5 of the 96 patients, the onset of the disease was so gradual or inadequately described in the records, that no attempt was made to assign this date. The fourth event, *the date of first symptoms,* was the most subjective, vague, and probably least reliable, especially in this retrospective record review. In 12 of the 96 patients, the records were inadequate for this judgment, but it was surprising how often it was possible. This attests, perhaps, to the acute nature of leukemia in children.

Results

Seasonal Variation: The monthly distribution of cases for the four events studied are shown in Fig. 1 and Table 1. The most striking and significant finding is the large number of cases having their *clinical onset*

from May to August. Approximately 49% of the cases occurred during that four-month-period, and the number of cases exceeded the monthly mean in each of those four months. When compared with the rest of the year, this phenomenon seemed unlikely to be attributable to chance ($p < .004$). A relatively small number of cases had their clinical onset in September to November (17%). This may have differed significantly from the remainder of the year ($p = .05$), but did not differ from the period of January to April. It was of interest that presumed mumps parotitis was the initial manifestation of disease in five cases beginning in March. Never fully recovering from this illness, these children soon underwent diagnostic efforts which led to appreciation of the leukemic process. All of the cases beginning with parotitis had their onset in March.

A large number of cases were *diagnosed* between June and September (44.7% of the total), and it did not seem likely this was due to chance ($p < .03$). A relatively small number of cases were diagnosed in October and November, and February had a higher than average number.

There were two noteworthy peaks in *mortality* distribution: January to March and July to August. Little can be said about the distribution of cases according to *first symptoms*. An early summer peak is again suggested; a mean of 8.4 cases per month was noted during the first seven months of the year, but only 5.3 for the last five.

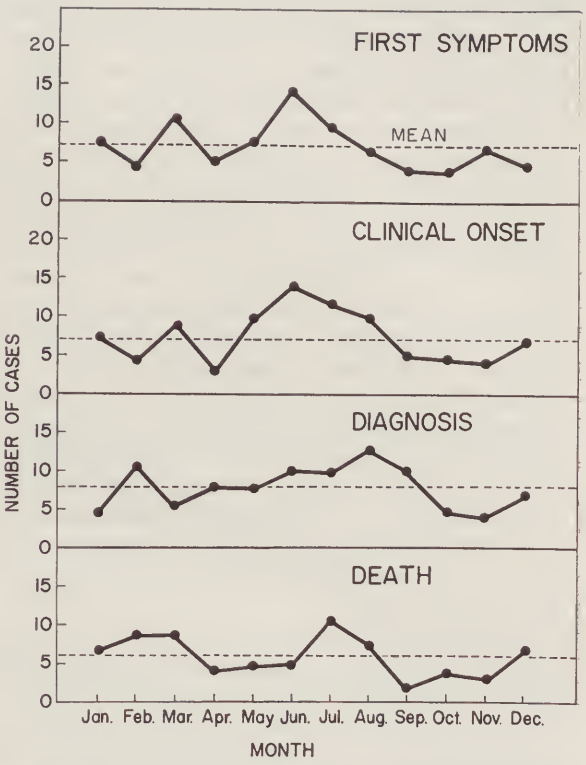


FIGURE 1: Monthly incidence of leukemia according to the four events studied. Data are adjusted to 30 day months.

TABLE 1: Seasonal Variation in the Onset of Leukemia

Month	Criteria Used to Determine Onset							
	First Symptoms		Clinical Onset		Diagnosis		Death	
	No.	%	No.	%	No.	%	No.	%
January	8	9.5	7	7.8	5	5.2	6	9.2
February	4	4.8	4	4.4	10	10.4	8	12.3
March	11	13.1	9	10.0	6	6.3	8	12.3
April	5	6.0	3	3.3	8	8.3	3	4.6
May	7	8.3	10	11.1	8	8.3	3	4.6
June	14	16.7	14	15.6	10	10.4	4	6.2
July	9	10.7	12	13.3	10	10.4	10	15.4
August	6	7.1	10	11.1	13	13.5	7	10.8
September	4	4.8	5	5.6	10	10.4	2	3.1
October	4	4.8	5	5.6	5	5.2	4	6.2
November	7	8.3	5	5.6	4	4.16	3	4.6
December	5	6.0	7	7.8	7	7.3	7	10.8
TOTAL	84		91		96		65	

This analysis suggested three things. First, acute childhood leukemia seemed to have a seasonal variation in its occurrence, with late spring and early summer being the peak period. Second, the seasonal variation was most pronounced the closer one got in the analysis to the true beginning of the disease. Third, variable and conflicting results were seen when later events (death) were studied. These results were

surprising to the authors, since we had expected to find a peak of clinical onset in the winter which might be related artifactually to the effects of seasonal respiratory infections calling attention to mild, early leukemia. Therefore, an attempt was made to further characterize and explain the summer peak.

The mean age (between 5 and 6 years) of the group of patients with clinical onset between May and August did not differ significantly from the entire group. The peak was seen from May to July with children less than 6 years of age; with children 6 or more years of age, June to August was the period of greatest incidence. The seasonal variation was seen with boys (51 patients), but especially with girls (40 patients). It was noted predominantly with white children (76 patients). The summer peak was noted for children residing in Baltimore city (39 patients) or in Maryland outside of Baltimore (24 patients), but not in those children who were referred from outside of Maryland. It was difficult to single out years in which the summer peak was most notable, but only 1951, 1954, 1957, 1958 and 1960 clearly showed the trend.

When cases were plotted by date of birth, no seasonal or temporal trends were seen. Fourteen cases were born in October (eight expected), but September and November births were fewer than expected, and the October births were distributed over ten different years.

There was no association between the summer peak, and the parents' age at the birth of the patient, or blood type. However, if those patients whose parents were 35 or more at the time of birth are disregarded, the seasonal pattern becomes exaggerated.

The clinical features of the onset of the leukemic illness in the summer was compared with those of the rest of the year (Table 2). According to the major manifestations leading to the recognition of the illness, there were no striking differences. It was true, however, that upper respiratory infections and adenopathy were more frequent during the winter. Patients presenting from May to August had a mean of 1.4 manifestations of the disease as presenting complaints; this figure was 1.6 for the rest of the year. Forty-eight cases were classified as acute lymphocytic leukemia and thirty-two as stem-cell leukemia. The summer peak was seen with both of these, but not with the remaining 11 monocytic or myelogenous leukemia patients.

The mean interval between the clinical onset and diagnosis for all cases was 2.3 months. The *mean* was 2.5 months in the summer, 2.0 for the rest of the year, 2.3 for whites, and 1.7 for Negroes. These differences are not statistically significant. In all of these groups, the *median* interval between onset and diagnosis was one month. The duration of the illness after diagnosis did not differ significantly according to season. The mean total duration of the illness with onset in summer was 7.1 months, and with onset in the winter 6.5 months (Table 3). The mean interval between diagnosis and death was 4.6 months in the summer, and 4.5 months in the winter. The mean initial hematocrit (28%) and total leukocyte count (28,000) did not differ significantly according to season of onset. These observations are summarized in Table 3 and suggest that the summer peak was not attributable to the influence of school schedules on the time of seeking medical care or to the stress of summer activities.

TABLE 2: Primary Factors in the Recognition of Acute Leukemia in Children

Manifestation	Frequency at Onset (% Patients)	
	May-August	September-April
Anemia and weakness	44	50
Infection	30	29
Bleeding	28	29
Pain (bone, muscle)	21	29
Fever	19	13
Adenopathy	2	11

The prevalence of cases under observation during the interval 1950 to 1962 ranged from 4.0 to 5.4 cases per month, with a mean of 4.7. No seasonal variation in prevalence was noted.

TABLE 3: Character of the Illness According to Season of Onset

Time of Onset	Interval in Months Mean and (Median)			Initial Hematocrit (Mean)	Initial Leukocyte Count (Mean)
	Onset to Diagnosis	Diagnosis to Death	Onset to Death		
May-August	2.5 (1)	4.6 (4.5)	7.1 (5.5)	29	28,000
Sept.-April	2.0 (1)	5.0 (4.5)	7.0 (5.5)	27	28,000

Discussion

These studies have demonstrated a seasonal variation in the onset of acute lymphocytic or stem-cell leukemia in children living in Maryland and presenting at The Johns Hopkins Hospital from 1950 to 1962. The phenomenon was especially notable in white girls, and in children whose parents were less than 35 years old. More cases seemed to begin in the late spring and early summer than can be accounted for on the basis of chance alone. They further suggest this variation is a true character of the disease not attributable to bias or artifacts in the selection presentation, or referral cases. That the observation is not an artifact related to the school schedule is suggested by the fact that it was observed in pre-schoolers, and by the fact that the illness did

not seem to be detected at different stages in the summer. The interval between clinical onset and diagnosis did not differ according to season. That the disease was not detected earlier or later in the course of the illness, because of the influence of climate or physical activity, was suggested by the data showing that the symptoms and laboratory findings at onset, and the total duration of the illness did not vary according to season. The phenomenon seems to be a true character of leukemia in this region.

When the reported studies on seasonal variations in the onset of leukemia in children are compared with ours, several observations are apparent. First, three of the nine studies are in agreement with ours. Second, those in disagreement are subject to certain statistical and methodological, as well as geographic criticisms. The early summer peak is in agreement with the data of Lec [7] and Knox,[8] and the young subgroup of undifferentiated cases reported by Fraumeni.[6] Lanzkowsky[5] and Hayes[4] found winter peaks. The cases in children under 12 reported by Scanu are suggestive of a summer peak, but he felt no trend could be seen.[10]

The significance of the seasonal variation is not clear. Certain speculations may be made concerning the implications of our results. First, there is no evidence they are related to radioactive exposure. The available evidence suggests that radioactivity is associated primarily with myelogenous leukemia and has a latent interval which is too long for a seasonal effect to be noticed.[1] While our data bear certain superficial resemblances to data on the seasonal onset of pellagra, the association of higher leukemia rates with a higher standard of living makes it unlikely that leukemia is a nutritional deficiency disease. Like pellagra, however, it may be that leukemia in some way is potentiated or accelerated by sunlight. We were unable to relate our data to any genetic factors (maternal age at birth, mongolism, blood type), but elimination of those patients whose parents were 35 years of age or older at the time of giving birth exaggerated the seasonal pattern. This is an important observation, and needs confirmation in larger studies. One of our patients had mongolism. A random sample seven times larger would ordinarily have been required for inclusion of one case of mongolism by chance alone.

One exception to the summer peak we noted involves those cases referred from south of Virginia. This tends to coincide with the data of Hayes [4] in which South Carolina patients under ten years of age were shown to have an increased incidence of *diagnosed* leukemia during February and March.

Another possible explanation for the seasonal pattern is that it is the result of seasonal variations in metabolic or hormonal activity. Blood cholesterol levels, thyroid and adrenal activity, and height- and weight-gain patterns are reported to show seasonal variation.[13] Thyroid and adrenal activity is increased during cold weather, and it may be that suppression of leukemia in its early stages occurs under these conditions, only to appear with the onset of warm weather and the decline in hormonal output. Brown showed that laboratory mice undergo seasonal variations in the growth of internal organs, including the thymus and lymphatic tissue.[14] Relative thymus weight was greatest from April to September in his mice. Susceptibility to experimental infection and tumorogenesis was highest in February and March, and lowest in June and July in his animals. We attempted to obtain evidence of seasonal variation in growth of internal organs in humans by reviewing the weights of internal organs in groups of children autopsied by the Medical Examiner in Baltimore because of accidental death. Our data were not sufficient to answer the question, however, and we have been unable to obtain evidence on this fundamental question elsewhere.

Lee has recently reported that neuroblastomas also appear in a seasonal pattern, with a summer peak similar to the one observed for leukemia.[15] If his observations are confirmed, it suggests either that numerous neoplasms are caused by infectious agents and have a similar latent period, or that the observed seasonal phenomenon represents a fundamental host process which influences the rate of tumor growth. Of the two hypotheses, the latter seems more plausible.

From the foregoing discussion, it is obvious that our data do not lend themselves solely to the conclusion that leukemia is a disease caused by an infectious agent. The most likely explanation for the seasonal variation is that it is related to infections, possibly in the winter, or to fundamental metabolic or hormonal influences upon tumor growth rates. Whatever the explanation, and there are undoubtedly others we have not considered, it would appear that the seasonal variation is a true character of childhood leukemia in Baltimore, and not an analytical artifact. As such, it is worthy of more intensive study, preferably in prospective studies, in carefully defined populations, in different regions and climates, and in different years. Such studies, if carefully controlled, may help to determine whether leukemogenesis is related to known, common infectious agents, or they may help define the epidemiology of still obscure, causative agents of leukemia. The possibility that metabolic hormonal, and even immunological factors are operative in humans to seasonally retard or accelerate the growth of malignant tissue is also obviously worthy of further study.

(See page 82 for a list of references)

your medical faculty at work

by John Sargeant
Executive Secretary

The Executive Committee met on Thursday, October 9, 1969, and took the following actions:

1. Heard that the Internal Revenue Service has notified the Faculty its tax returns are in order;
2. Agreed to establish specific dates and to meet biennially with the Hospital Council Executive Committee to discuss mutual areas of concern—this is subject to Hospital Council approval;
3. Agreed to add the name of the Secretary of Health and Mental Hygiene to the mailing list of the Faculty's House of Delegates;
4. Endorsed a proposal from the U.S. Pharmacopeia for a commemorative stamp on the occasion of the 150th anniversary of this publication;
5. Endorsed the principles enumerated by the Consumer Credit Counseling Service, a nonprofit organization, on the basis that cooperation on the part of physicians is voluntary;
6. Agreed to cooperate with the Department of Health and Mental Hygiene in connection with an "in-depth" study of the physician manpower shortage;
7. Agreed to establish an Advisory Council on Human Trials that would advise the Secretary of Health and Mental Hygiene in connection with human trial projects;
8. Discussed, at considerable length, specific cases of alleged professional liability, authorized legal defense and employment of additional legal counsel in certain cases; and requested the President to call a special meeting of the Faculty's House of Delegates to consider bylaw changes in this connection and discuss the general problem of malpractice actions in Maryland;
9. Authorized designation of a representative to attend an all-day session dealing with the future role of the U.S. Pharmacopeia;
10. Authorized the Faculty's auxiliary to receive credit for collection of AMA-ERF funds through the Faculty;
11. Renamed several physicians to the Medical Advisory Board of the Red Cross Blood Program;
12. Endorsed a project request for Tuberculosis control as requested by the Baltimore City Health Department;
13. Authorized appointment of a special group of physicians to serve on a continuing committee to involve Peer Review;
14. Endorsed a request that a nonprofit group be established for the operation of the Preschool Hearing and Vision Screening Survey with the Faculty to name four members of the seven member board; and the Maryland Society for Prevention of Blindness to name the remaining three members. The Executive Committee also made the sum of $5,000 available for this group to initiate the project and get the program underway.

ETHICS CORNER

In regard to the recent proliferation of charge cards, particularly as they apply to the medical field, it is important that physicians fully understand the ethics involved in the acceptance and use of such charge cards in their practice.

As early as 1963, the Medical and Chirurgical Faculty frowned upon the use of charge cards that lumped medical bills with other services or items purchased by an individual. The Faculty stressed the importance of keeping such charges completely separate from medical fees; and the need to ensure that the fee charged the patient was not increased by the use of such charge services. The Faculty has, in some instances, ruled that the use of specific charge cards or services is unethical. In other instances, it has found that the use of such services is ethical. Each case is decided on the individual arrangement between the patient, the physician, and the charge service. In the latest issue of AMA's Judicial Council opinions, which the Faculty's Bylaws require physicians to abide by, the following summary is provided:

In connection with physician participation in bank card programs, the Judicial Council recommends the following principles to be implemented and applied as necessary by the county medical society for the guidance of physicians as these programs develop.

(1) The county medical society should be satisfied as to the financial and professional integrity of the plan. It should negotiate with the plan sponsors to insure that service charges to the physician are reasonable. It should insist that the plan be open to all physicians on the same terms and that it not exploit or capitalize on physicians' participation in the plan. It should advise the plan that the listing of physicians in directories of participating members is contrary to the ethics of the medical profession.

(2) The individual physician may not, because of his participation, increase his fee for medical service rendered the patient. He may not use the plan to solicit patients. He may not encourage patients to use the plan. His position must be that he accepts the plan as a convenience to patients who desire to use it. Plaques or other devices indicating participation in the plan within the physician's office shall be kept to a discreet and dignified minimum. Plaques, signs, or other devices indicating such participation visible outside the physician's office are unacceptable.

(3) The use of a bank card in connection with the payment of larger fees—which might normally be paid to the physician in installments—is not to be encouraged. All members of the Association are expected to continue the traditional practice of permitting patients of limited means to pay relatively large fees in installments without interest or carrying charges. Out of respect for the dignity and traditions of the medical profession, the physician may not relieve himself of his obligations "to render service to humanity, reward or financial gain being a subordinate consideration."

For elderly patients in need of a mild tranquilizer consider **Tybatran**®

brand of tybamate

(When you consult the Prescribing Information you may agree it makes good sense)



PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

Cephaloridine Dosage . . .

(Continued from page 69)

REFERENCES

1. Kislak, J. W., Steinhauer, B. W., and Finland, M: Cephaloridine Activity in Vitro and Absorption and Urinary Excretion in Normal Young Men, *AJ Med Sci* **251:**433-448, 1966.
2. Welles, J. S., et al: Toxicity, Distribution, and Excretion of Cephaloridine in Laboratory Animals, *Antimic Ag& Chemo,* 863-869, 1965.
3. Hamilton-Miller, J. M. T., Smith, J. T., and Knox, R.: Interaction of Cephaloridine with Penicillinase Producing Gram-Negative Bacteria, *Nature,* **208:**235-237, 1965.
4. Apicella, M. A., Perkins, R. L., and Saslaw, S.: Cephaloridine Treatment of Bacterial Infections, *AmJMedSci,* **251:**266-267, 1966.
5. Steigbigel, N. H., McCall, C. E., Reed, C. W., and Finland, M.: Antibacterial Action of "Broad-Spectrum" Penicillins, Cephalosporins, and Other Antibiotics Against Gram-Negative Bacilli Isolated from Bacteremic Patients, *Ann NY Acad Sci,* **145:**224-236, 1967.
6. Kabins, S. A., and Cohen, S.: Cephaloridine Therapy as Related to Renal Function, *Antimic Ag& Chemo,* 922-932, 1965.
7. Hermans, P. E., Martin, J. K., Jr., Needham, G. M., and Nichols, D. R.: Laboratory and Clinical Evaluation of Cephaloridine, a Cephalosporin Derivative, *Antimic Ag& Chemo,* 879-887, 1965.
8. Hinman, A. R. and Wolinsky, E.: Nephrotoxicity Associated with the Use of Cephaloridine, *JAMA,* **200:**724-761, 1967.
9. Muggleton, P. W., O'Callaghan, C. H., and Stevens, W. K.: Laboratory Evaluation of a new Antibiotic—Cephaloridine (Ceporin), *Brit Med J,* **2:**1234-1237, 1964.
10. Sell, S. H. W.: In Vitro Sensitivity Studies of Hemophilus Influenzae Typable and Non-typable Strains, *Ped,* **39:**214-219, 1967.
11. Flux, M., Nunnery, A. W., and Riley, H. D., Jr.: Evaluation of Cephaloridine in Infants and Children, *Antimic Ag& Chemo,* 933-936, 1965.
12. Taber, L. H., Yow, M.D., and Nieberg, F. G.: The Penetration of Broad Spectrum Antibiotics into the Cerebrospinal Fluid, *Ann NY Acad Sci,* **145:**473-481, 1967.
13. Gonnella, J. S., Olexy, V. M., and Jackson, G. G.: Cephaloridine Treatment of Bacterial Infections, *Antimic Ag& Chemo,* 901-907, 1965.

Season and the Onset of Leukemia . . .

(Continued from page 77)

REFERENCES

1. Dameshek, W., and Gunz, F.: *Leukemia,* New York: Grune and Stratton, 1964.
2. Heath, C. W. and Hasterlik, R. J.: Leukemia Among Children in a Suburban Community, *Amer J Med* **34:**796-812, 1963.
3. Miller, R. W.: Radiation, Chromosomes and Viruses in the Etiology of Leukemia, *New Eng J Med* **271:**30-36, 1964.
4. Hayes, D. M.: The Seasonal Incidence of Acute Leukemia, *Cancer* **14:**1301-1305, 1961.
5. Lanzkowsky, P.: Variation in Leukemia Incidence, *Brit Med J* **1:**910, 1964.
6. Fraumeni, J. F.: *Brit Med J* **2:**1408-1409, 1963.
7. Lee, J. A. H.: Seasonal Variation in the Clinical Onset of Leukaemia in Young People, *Brit Med J* **1:**1737-1738, 1962.
8. Knox, G.: Epidemiology of Childhood Leukemia in Northumberland and Durham, *Brit J of Preventive and Social Medicine* **18:**17-24, 1964.
9. Bjelkel, E.: Leukemia in Children and Young Adults in Norway, *Cancer* **17:**248-255, 1964.
10. Scanu, A.: Frequenza Stagionale delle emopatic acute e subacute di tipo leucemico in Compania e in Sardegna, *Riforma med* **68:**449-452, 1954.
11. Till, N. W., et al: Childhood Leukemia in Greater London: A Search for Evidence of Clustering, *Brit Med J* **3:**755-758, 1957.
12. Gunz, F. W., and Spears, G. F. S.: Distribution of Acute Leukemia in Time and Space, Studies in New Zealand, *Brit Med J* **4:**604-608, 1968.
13. Okamoto, M.; Kohzuma, K.; and Horiuchi, Y.: Seasonal Variation of Cortisol Metabolites in Normal Man, *J Clin Endocrin* **24:**470-471, 1964.
14. Brown, W. H.: Constitutional Variation and Susceptibility to Disease, *Arch Internal Med* **44:**625-662, 1929.
15. Lee, J. A. H.: Summer and Death from Neuroblastoma, *Brit Med J* **2:**404-407, 1967.

Sudden Unexpected Death . . .

(Continued from page 72)

REFERENCES

1. Wedgewood, R. J., and Benditt, E. P.: Sudden Death in Infants: Proceedings of the conference on causes of sudden death in infants. U. S. Public Health Service Publ. No. 1412, Seattle, Washington, Sept. 1963.
2. Fisher, R. S., Katz, S. S., and Lovitt, W. V.: Sudden deaths in infancy. A sociopathological study. Report from the Office of the Chief Medical Examiner of Maryland and Department of Legal Medicine, Baltimore: University of Maryland Medical School, 1959.
3. Valdes-Dapena, M. A.: Sudden and Unexpected Death in Infancy: A review of the World Literature, 1954-1966. *Pediatrics* **39:**123, 1967.
4. Muller, G.: Sudden Death in Infants: Pathological anatomy and dynamics. *Acta Paediat* (Stockholm), **53:**600, 1964.
5. Bark, C. J., and Perzik, S. L.: Mikulicz's Disease, Sialoangiectasis, and Autoimmunity Based Upon a Study of Parotid Lesions. *Am J Clin Path* **49:**683-689, 1968.
6. Thygeson, P.: The Cytology of Conjunctival Exudates, *Am J Ophthamol* **49:**1499-1515, 1946.
7. Theodore, F. H., and Schlossman, A.: *Ocular Allergy,* Baltimore, *Williams and Wilkins,* p. 140, 1958.
8. Stowens, D., Callahan, E. L., and Clay, J.: Sudden Unexpected Death in Infancy, a new hypothesis of cause. *Clin Pediat* **6:**243, 1966.

RUG CLEANING
Of the Highest Quality at Reasonable Prices
ORIENTAL & DOMESTIC
• Repairing • Storing
• Installing • Moth-proofing
Expert Oriental Rug Repairing & Reweaving
SPECIALISTS IN CLEANING WALL-TO-WALL CARPETS AND FURNITURE IN YOUR HOME
A large selection of Antique and Modern Oriental Rugs and Carpets Available
EST. 1922
Hanna
IMPORTER
HOpkins 7-6600
2015 W. 41st ST.
Baltimore, Md. 21211

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.



The pain of earache was allegedly relieved by holding a hot roasted onion to the ear.



r headache, a sovereign remedy was wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

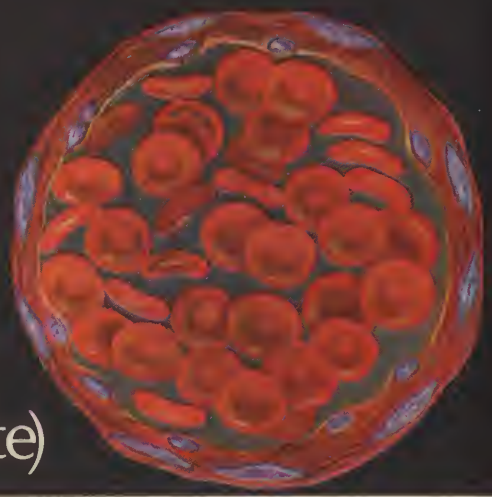
Keeps the promise of pain relief

'B. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

Roniacol® Timespan®

(nicotinyl alcohol tartrate)



Because peripheral vasodilation is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy.

Prolonged, continuous drug release—Prolonged peripheral vasodilation is provided sustained-release Roniacol Timespan (nicotinyl alcohol tartrate) Tablets. Part of the drug becomes available immediately, the remainder continuously over a period of up to 12 hours and dilation of constricted peripheral vessels usually maintained. Thus, with a single dose of medication, patients can enjoy the benefits of increased peripheral blood flow in ischemic extremities for up to 12 hours.



Smooth peripheral vasodilation from initial dosage...extended with simple, well-tolerated, b.i.d. dosage

...ne prolonged action of Roniacol Timespan ...nicotinyl alcohol tartrate) together with its ...the benefits offer a therapeutically practical ...ea re in the long-term management of ...eripheral vascular disease–advantages ...pecially important for older patients.

...efo prescribing, please consult complete ...odct information, a summary of which ...llows:

...dications: Conditions associated with ...efficient circulation; *e.g.*, peripheral vascular ...sease, vascular spasm, varicose ulcers, ...ecutal ulcers, chilblains, Meniere's syn...om and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE

Roche
LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.


Food 'n mouth disease

reludin® phenmetrazine hydrochloride
reludin is indicated only as an anorexigenic agent in the treatment of obesity. It may be used in simple obesity and in obesity complicated by diabetes, moderate hypertension (see Precautions), or pregnancy (see Warning).

ontraindications: Severe coronary artery disease, hyperthyroidism, severe hypertension, nervous instability, and agitated prepsychotic states. Do not use with other CNS stimulants, including MAO inhibitors.

arning: Do not use during the first trimester of pregnancy unless potential benefits outweigh possible risks. There have been clinical reports of congenital malformation, but causal relationship has not been proved. Animal teratogenic studies have been inconclusive.

Precautions: Use with caution in moderate hypertension and cardiac decompensation. Cases involving abuse of or dependence on phenmetrazine hydrochloride have been reported. In general, these cases were characterized by excessive consumption of the drug for its central stimulant effect, and have resulted in a psychotic illness manifested by restlessness, mood or behavior changes, hallucinations or delusions. Do not exceed recommended dosage.

Adverse Reactions: Dryness or unpleasant taste in the mouth, urticaria, overstimulation, insomnia, urinary frequency or nocturia, dizziness, nausea, or headache.

Dosage: One 25 mg. tablet b.i.d. or t.i.d. Or one 75 mg. Endurets tablet a day, taken by midmorning.

Availability: Pink, square, scored tablets of 25 mg. for b.i.d. or t.i.d. administration, in bottles of 100 and 1000.
Pink, round Endurets® prolonged-action tablets of 75 mg. for once-a-day administration, in bottles of 100 and 1000.
(B)R3-46-560-B

Under license from Boehringer Ingelheim G.m.b.H.

For complete details, please see full prescribing information.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

For some, obesity can be a serious complication of moderate hypertension, diabetes, or pregnancy.

Preludin may be used to curb appetite in obesity associated with such conditions.

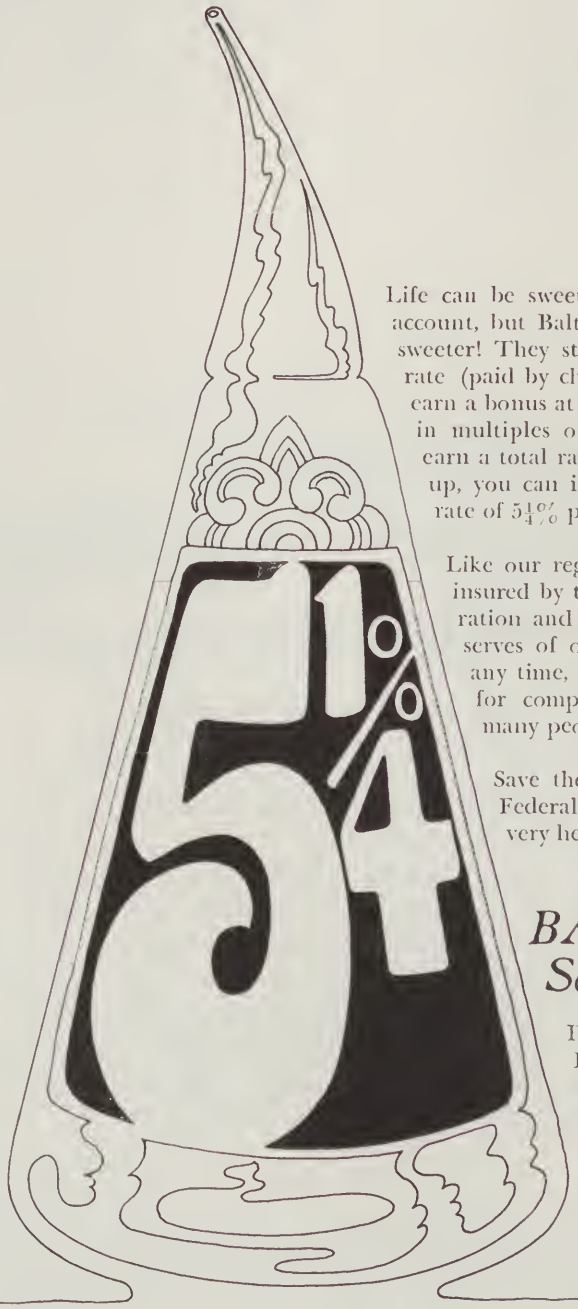
For use during pregnancy, please consult Warning paragraph. The use of Preludin in moderate hypertension should be accompanied by caution. In diabetes, the drug does not increase insulin requirements (requirements may be reduced as weight is lost).

One 75-mg. Endurets tablet taken between breakfast and midmorning will usually provide daylong and early-evening suppression of appetite.

Preludin® phenmetrazine hydrochloride **Endurets®** prolonged–action tablets

PR 11

THE SWEETENER



Life can be sweet when you have a Baltimore Federal savings account, but Baltimore Federal Savings Certificates can be even sweeter! They start by earning interest at our current interest rate (paid by check at regular quarterly interest periods), then earn a bonus at maturity. You can invest from $1,000 to $11,000 in multiples of $1,000 for either six months or a year and earn a total rate of 5% per annum guaranteed! From $12,000 up, you can invest for either period and earn a guaranteed rate of 5¼% per annum.

Like our regular passbook savings account, your money is insured by the Federal Savings and Loan Insurance Corporation and further backed by Baltimore Federal's own reserves of over $25,000,000. Certificates may be cashed at any time, earning interest at our regular rates. Of course, for complete flexibility combined with high interest, many people still prefer our passbook accounts.

Save the way it suits you best . . . any of Baltimore Federal's five plans sweetens your savings with some very heavy sugar.

BALTIMORE FEDERAL
Savings & Loan Association

Downtown at Fayette and St. Paul Streets • Eastpoint Shopping Center • Reisterstown Road Plaza • Towson at 7 Alleghany Ave. • Carney at 9609 Harford Road • Yorktowne Plaza Shopping Center • Columbia, Teachers Building • Westminster at 6 E. Main Street.



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

Help! Help!
Second Installment of HELP!

As a follow-up to the October issue's library page, the following projection table shows the number of hospitals whose library facilities are presently inadequate, adequate now—not in the future, and adequate for two to three years.

PROJECTIONS FROM THE NATIONAL HOSPITAL PANEL SURVEY FEBRUARY, 1969

	Number of Hospitals	Number of Beds	Number of Hospitals Whose Library Facilities are:		
			Presently Inadequate	Adequate Now-Not in Future	Adequate for 2-3 years
All Community Hospitals	5,872	772,503	1,331	1,599	2,913
Hospital Size					
6- 24 beds	547	9,090	87	100	330
25- 49 beds	1,439	51,350	304	427	706
50- 99 beds	1,484	103,501	239	409	836
100-199 beds	1,139	158,467	291	347	501
200-299 beds	567	136,925	181	122	254
300-399 beds	302	102,482	122	47	133
400-499 beds	154	68,195	22	69	76
500 +	240	142,493	85	78	77
Region					
New England	302	45,649	47	91	164
*Middle Atlantic	698	159,340	179	152	367
South Atlantic	792	102,813	132	275	385
East North Central	930	154,180	204	237	489
East South Central	468	46,031	144	174	120
West North Central	774	77,100	130	138	506
West South Central	819	70,466	276	89	467
Mountain	347	29,480	55	123	167
Pacific	742	87,444	164	320	248

*Maryland falls in this area.

Since Maryland is located in the Middle Atlantic region, ranking sixth in the number of hospitals in the country, the need for an increased hospital library staff and expanded facilities in our region becomes evident.

Because of federal libraries and other medical and paramedical institutions found in the region, Maryland fortunately possesses resource facilities not available to many other areas. The great disadvantage of our proximity to Bethesda, however, is the lack of a regional medical library for this area. Smaller libraries are hampered by not having a central intermediary source specifically designed to handle interlibrary loans, and the National Library of Medicine is reluctant to process requests for material available in the state.

Lost Book

One book must have wandered away from the library exhibit taken to Hershey for the semiannual meeting. If, by any chance, the following title shows up on your shelves, please return it to the Med/Chi Library:

Cardiac diagnosis, by Noble O. Fowler. 1968

Regional Medical Library Association Meeting

The MLA regional meeting will be held on Saturday, November 22, at NIH in Bethesda. Notices will be forthcoming. If you have any news of Maryland medical libraries, please send a notice to Elizabeth Sanford, Librarian, Medical and Chirurgical Faculty of Maryland, 1211 Cathedral St., Baltimore, Maryland 21201.

Want Any Old Books?

Again, a collection of duplicate copies of books being withdrawn from the library holdings is offered to any member of the Faculty who is interested in scanning the titles and selecting items he might want to add to his own library.

We ask that any physician choosing to take books from this collection, please refrain from selling them to book stores or dealers.

TOWSON TELEPHONE SECRETARIES

Mrs. Isabel Flanagan—Owner

WE ANSWER YOUR PHONE
24 HOURS A DAY — EVERY DAY

MONTH - TO - MONTH BASIS
ORDER BY PHONE

"INSURE YOURSELF AGAINST LOSS OF PATIENTS' CALLS"

7112 York Rd. 825-1300
Just below Stevenson Lane TOWSON, MD.

For your next meeting, banquet or convention . . . consider



THE NEW OCEAN CITY CONVENTION HALL

One of the most beautiful facilities on the east coast—ideal for sales meetings, private parties, banquets, conventions, trade shows . . . concerts, dances and sporting events. Will accommodate up to 2000 at a banquet, 3000 at a convention; meeting rooms for 50 to 300 persons. Air-conditioned and heated—for year-round use. Large private parking area.

For complete information . . . . write
EARL G. BAIRD, *Executive Director*
4000 Philadelphia Ave., Ocean City, Md. 21842

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL **MED-ICAL**
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

New Appointments

Dr. Carr—Local Health Services

James D. Carr, MD, has been appointed Assistant Commissioner of Health for local health services in the Baltimore City Health Department, effective August 18. Formerly Director of Medical Education at Provident Hospital, Dr. Carr will administer the activities of the city's health districts, coordinating, evaluating, and programming the preventive and treatment services available to residents on a neighborhood basis.

As a native Baltimorean and a lifetime resident of the city, Dr. Carr has been associated with the City Health Department since 1941 as a part-time clinic physician in the division of venereal diseases, and more recently as a school physician examining children and directing their treatment and care.

Dr. Carr attended the public schools of Baltimore and graduated from Douglass High School. He received his BS degree from Morgan State College in 1929 and the MD degree from Howard University Medical School in 1935. Following internship and residency at Provident Hospital, Dr. Carr entered private practice and assumed part-time medical and administrative duties at the hospital. In 1964, he was named Provident's Chief of Staff, and in 1966 became Director of Medical Education.

Dr. Carr is a member of the Monumental Medical Association, the Medical and Chirurgical Faculty of Maryland, the National Medical Association, the American Heart Association, the American Association for Continuing Hospital Medical Education, the Omega Psi Phi Fraternity, and the American Association of Health, Physical Education and Recreation.

Dr. Berzon—Veterinarian

David R. Berzon, DVM, has been appointed Public Health Veterinarian, a new post in the Baltimore City Health Department. Formerly Director of the Bureau of Meat Inspection, Dr. Berzon will supervise the enforcement of municipal ordinances and regulations governing animal diseases transmissible to man, as well as those laws dealing with the humane treatment of animals. In addition, he will serve as a consultant in the investigation of illnesses suspected to be of animal origin, and will maintain a close liaison with state and federal veterinary regulatory agencies and organizations.

Dr. Berzon has been with the Baltimore City Health Department since 1961, and has been Director of the Bureau of Meat Inspection since 1965. On July 1, the work of this bureau was integrated with the State Board of Agriculture through the enactment of the Maryland Wholesome Meat Act, whereby staff members were transferred to other posts in the department or to the Meat Inspection Service of the State Board of Agriculture.

In 1966, Dr. Berzon was coordinator of the Baltimore Anti-Rabies Campaign, and was highly instrumental in the success of this program in which over 6,000 dogs were protected with anti-rabies vaccine in a two-day period.

Dr. Berzon received his DVM degree from the University of Georgia in 1954 and the Master of Public Health degree from The Johns Hopkins School of Hygiene and Public Health in 1968. He has been in private practice, and for three years was a veterinarian with the United States Department of Agriculture. During the Korean emergency, he served as officer-in-charge of preventive medicine programs at four United States Air Force bases overseas. Dr. Berzon attended the St. Louis University School of Law. He is a member of the American and Maryland State Veterinary Medical Associations.

THE DAY OF THE LONE (INSURANCE / MUTUAL FUND) WOLF IS OVER

AN INCREASINGLY COMPLEX AND SOPHISTICATED WORLD HAS PASSED HIM BY

WE ARE A TEAM OF SPECIALISTS

ON OUR TEAM IS A SPECIALIST IN KEOGH PLANS
(HIS ARTICLES IN THIS FIELD ARE NATIONALLY KNOWN!)

ON OUR TEAM IS A SPECIALIST IN MUTUAL FUNDS
(IN CONSTANT CONTACT WITH OLD FRIENDS ON WALL STREET!)

ON OUR TEAM IS A SPECIALIST IN TAX-SHELTERED METHODS OF PURCHASING LIFE-INSURANCE AND MUTUAL FUNDS
(18 YEARS IN THIS FASCINATING AND COMPLEX SPECIALTY!)

ON OUR TEAM IS A SPECIALIST IN ACCIDENT AND SICKNESS INSURANCE
(30 YEARS IN THIS SPECIALTY!)

ON OUR TEAM IS A SPECIALIST IN ESTATE PLANNING
(KNOWN AND RESPECTED AS BOTH TEACHER AND PRACTITIONER!)

ALL THESE PEOPLE ARE AT YOUR SERVICE
(HOW CAN ONE MAN POSSIBLY COVER ALL THIS GROUND–IN DEPTH?!)

SECURITY HOUSE, Inc. and affiliates

539–5900

THE HOUSE OF SPECIALISTS
(IN INSURANCE AND MUTUAL FUNDS)



A Service of the Tuberculosis Association of Maryland

tuberculosis

Survival of Acute Respiratory Failure

A study was made of 239 episodes of acute respiratory failure in 146 patients with chronic respiratory insufficiency. Twenty percent of the patients survived at least 30 months. Survival rates were lowest for patients with diffuse infiltrative disease.

A study was undertaken to determine the survival time of chronic lung disease patients after an episode of acute respiratory failure, and to ascertain whether clinical and physiological findings correlated with survival.

Accordingly, 146 men treated at the Veterans Administration Hospital, Durham, N.C., for 239 episodes of acute respiratory failure were studied prospectively over a four-year period.

Each patient was classified as belonging to one of six groups on the basis of clinical and roentgenographic characteristics of his disease. The groups and the number of patients and episodes, respectively, in each category were: I, Chronic diffuse infiltrative disease—13, 22; II, Hyperinflated lungs (emphysema) without hypercapnia—33, 43; III, Hyperinflated lungs with hypercapnia—36, 44; IV, Hyperinflated lungs with hypercapnia and bronchitis—31, 63; V, Chronic bronchitis with hypercapnia but without hyperinflated lungs—20, 33; and VI, obese bronchitis—13, 34.

Calculations were made of vital capacity, forced vital capacity (FVC), forced expiratory volume in 0.5 and in 1.0 second ($FEV_{0.5}$ and FEV_1), maximal inspiratory flow rate (MIFR), maximal expiratory flow rate (MEFR), and maximal midexpiratory flow rate (MMEF).

Measurements were made of arterial blood carbon dioxide and oxygen tensions and pH within ten minutes of obtaining samples, which often was at the time the patient arrived at the hospital.

Respirator Assistance

Pressure-cycled respirators were used to control ventilation in 64 episodes, to assist ventilation in 54, and intermittently to assist it in all other episodes. Patients requiring controlled ventilation had more severe respiratory failure than the others. However, no general conclusions on survival prognosis of the individual patient should be drawn from this. For a few patients with severe bronchitis, the high pressures of a volume-cycled respirator were needed to maintain adequate ventilation.

The 100 patients in groups II, III, and IV had X-ray evidence of emphysema. One third of these had P_aco_2 below 50 mm Hg while the others had sustained P_aco_2 elevations during respiratory failure.

In age, the patients ranged from 35 to 88 years, with a mean of 61. Mean ages at onset of acute respiratory failure were highest (63 and 64 years, respectively) in groups II and III (emphysema without clinical chronic bronchitis).

Pulmonary emphysema patients without clinical bronchitis (groups II and III) had a mean weight of 120 lb in contrast to a mean of 169 lb in those with chronic bronchitis without emphysema (group V). The mean weight of patients with emphysema

Tryggvi Asmundsson, MD, and Kaye H. Kilburn, MD, *Annals of Internal Medicine,* March, 1969.

and bronchitis (group IV) was midway between that of groups II and III and of group V. The obese patients (group VI) had a mean weight of 277 lb.

The obese patients had been dyspneic for only 4.5 years before the onset of respiratory failure. Patients in all other groups had been dyspneic for a period of 9.8 to 12.8 years. There was no clear relationship between dyspnea and objective evidence of ventilatory insufficiency.

Although vital capacity was reduced in all patients, the greatest reduction was in those with pulmonary emphysema and hypercapnia. The obese patients had the greatest number of recurrent episodes.

Of 146 patients, 135 smoked cigarettes. Most had smoked 20 or more cigarettes a day for 20 years. Two patients had smoked a pipe. Only nine had never smoked.

Survival Rates

Patients survived 162 (68%) of the 239 episodes. Eighty-seven survived the initial episode and 81 of these were alive six months later. After two and a half years, the survival rate had fallen to about 20% and remained constant for patients followed for four years. This was in contrast to the expected four-year survival rate of 89% for unselected men of 61 years of age in this country, an indication of the excessive mortality of patients in acute respiratory failure.

Only 15% of the patients with diffuse infiltrative disease survived six months or longer, compared with 30% of those with emphysema without hypercapnia; 39% of those with emphysema and hypercapnia; 23% of those with chronic bronchitis and emphysema; 55% of those with chronic bronchitis; and 69% of the obese-bronchitic group.

Three of the 13 patients with diffuse chronic infiltrative disease had a short, fatal course and had the Hamman-Rich syndrome. The other ten had a more protracted illness. Survival of the group was uniformly poor after onset of acute respiratory failure.

All patients with pulmonary emphysema had a serious prognosis. The chronic bronchitis patients without emphysema had a significantly better chance of survival than those without significant hypercapnia. The chronic bronchitis patients without emphysema had a significantly better survival than the three groups of patients with emphysema. This would be expected because exacerbations of bronchitis are potentially reversible, but the destruction of alveoli in emphysema is permanent.

Several factors may have influenced survival of the obese patients. Their average age was ten years less than the average age of patients in other groups and pulmonary function impairment was less severe than among the other groups. Obese patients who did not regain lost weight had no recurrence of respiratory failure.

Preservation of airflow and vital capacity correlated with survival and, conversely, airway obstruction as measured by decreased MMEF rates correlated with poor long-term survival. Severe impairment of gas exchange suggested a poor prognosis after an episode of respiratory failure.

Anemia and, to a lesser degree, edema, were also predictive of poor survival. Loss of hemoglobin reduces the oxygen-carrying capacity of the blood and low arterial oxygen tension is therefore less well tolerated. Edematous patients had a shorter survival after the initial episode than the nonedematous patients, but the difference was not statistically significant.

Patients who survived for 30 months appeared to have a death rate comparable to that of the normal male population of the same age. In this study no factor was identified as common to patients with long survival. Therefore, each patient must be treated as if he were among the 20% who will survive 30 months.

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS
AND LOAN ASSOCIATION
INCORPORATED 1907
421 NORTH CHARLES STREET
CORNER FRANKLIN STREET
BALTIMORE, MARYLAND 21201
PHONE 752-6000

Visit the #1 Spot for Your Diet Needs
Now in our new location
1 No. Howard St.
(Corner of Baltimore St.)
For the Food Your Doctor Advises
● Low Sodium ● Sugar-free ● Non-allergic
SPECIAL DIET SHOP
Phone SA 7-0383

One of these disposables comes prefilled.
Its unit dose – in nonreactive glass
cartridge – is premeasured.
The cartridge is clearly labeled:
drug name, strength, control number.
Even expiration date where appropriate.

You're more confident that the patient gets...





. . . just what the doctor ordered with the Tubex Closed Injection System.

Injections with the Tubex system are as easy as 1, 2, 3,

1. Select—from an extensive variety of prefilled Tubex sterile cartridge-needle units.* No multi-dose vials to bother with; no unlabeled syringes to cause confusion.

2. Inject—with a minimum of pain. Thanks to the single-use, stainless-steel needle that's both ultra-sharpened and siliconized. Aspirate simply and conveniently.

3. Throw away—empty cartridge-needle unit. Never used again, it can't transmit infection. And there's no clean-up job.

*For injectables not yet in the ever-expanding prefilled Tubex line, empty sterile cartridge-needle units are available.

TUBEX®

Closed Injection System
Hypodermic Syringe
Sterile Cartridge-Needle Unit

Wyeth® UD UNIT DOSE MEDICATION™

Wyeth Laboratories Philadelphia, Pa.

WILLIAM J. PEEPLES, MD, MPH, COMMISSIONER

Maryland State department of health

Medical Assistance Advisory Committee

Neil Solomon, MD, Secretary of Health and Mental Hygiene, recently announced the appointment of 24 members to the newly constituted Medical Assistance Advisory Committee.

The Committee, required by Federal Legislation, will advise the Secretary on broad policy matters relating to the administration of the state's Medicaid program.

Dr. Solomon said that Medicaid has been budgeted with over $74 million for fiscal 1970 which probably represents the largest investment by the State of Maryland in the health of its citizens.

He noted that the members of the Committee were selected from a wide variety of health professions including medicine, pharmacy, dentistry, nursing, hospitals, and public health services.

Named Chairman of the Medical Assistance Advisory Committee was Louis L. Randall, MD, President of the Monumental City Medical Society. Others appointed were: William L. Stewart, MD, President, Maryland Academy of General Practice; Howard E. Hall, MD, of Sykesville, Md.; Robert W. Gibson, MD, Medical Director, the Sheppard-Enoch Pratt Hospital; Emerson C. Walden, MD, John T. Chissell, MD, Raymond L. Gray, DDS, Mr. Bernard B. Lachman of Baltimore; Richard Hollander, MD, of Silver Spring, and Mr. Denwood Kelly, President, Blue Shield.

Hospital officials appointed to the Committee were: Reginald H. Dabney, President, Maryland Hospital Services; Harry W. Penn, Jr., Administrator, Prince George's General Hospital; J. Emmett Queen, MD, Director of Medical Education, Bon Secours Hospital; and Henry J. Whyte, Administrator, Provident Hospital.

Government and public health officials named were: William J. Peeples, MD, Commissioner, State Health Department; Robert E. Farber, MD, Commissioner, Baltimore City Health Department; Raleigh C. Hobson, Director, State Department of Social Services; Maurice A. Harmon, Director, Baltimore City Department of Social Services; Alice B. Tobler, MD, Director of Mental Health Planning, State Department of Mental Hygiene; and Benjamin D. White, MD, Director, Bureau of Preventive Medicine, State Health Department.

Also appointed were: Walter Granruth, MD, Baltimore County; William J. Kinnard, Jr., MD, Dean of the School of Pharmacy, University of Maryland; James P. Cragg, Jr., Baltimore; Miss Patricia Lusk, Prince George's County Health Department; Mrs. Vivian Pendleton, Baltimore City Health Department; Roger C. Lipitz, and Mrs. Elsie E. Bumbry.

The Apprehensive Hypertensive





Regroton® to lower blood pressure

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Regroton®: chlorthalidone 50 mg., reserpine U.S.P. 0.25 mg.
Indications: Hypertension. *Contraindications:* History of mental depression, hypersensitivity, and most cases of severe renal or hepatic diseases. *Warning:* With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has frequently been required and deaths have occurred. Discontinue coated potassium-containing formulations immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur. Discontinue one week before electroshock therapy, and if depression or peptic ulcer occurs. *Use in pregnancy:* Because chlorthalidone may cross the placental barrier and appear in cord blood and thiazides may appear in breast milk, this drug should be used with care in pregnant patients and nursing mothers. When used in women of childbearing age, the potential benefits of the drug should be weighed against the possible hazards to the fetus. Use of chlorthalidone may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. Increase respiratory secretions, nasal congestion, cyanosis and anorexia m occur in infants born to reserpine-treated mothers. *Precautions:* Antih pertensive therapy with this drug should always be initiated cautious in postsympathectomy patients and in patients receiving ganglion blocking agents, other potent antihypertensive drugs, or curare. Reduc dosage of concomitant antihypertensive agents by at least one-half. T avoid hypotension during surgery, discontinue therapy with this age two weeks prior to elective surgical procedures. In emergency surger use, if needed, anticholinergic or adrenergic drugs or other supporti measures as indicated. Because of the possibility of progression renal damage, periodic kidney function tests are indicated. Discontinu if the BUN rises or liver dysfunction is aggravated. Hepatic coma ma be precipitated. Electrolyte imbalance, sodium and/or potassium de pletion may occur. If potassium depletion should occur during therap the drug should be discontinued and potassium supplements given provided the patient does not have marked oliguria. Take particular care in cirrhosis or severe ischemic heart disease and in patients receiving





and allay anxiety in hypertension

orticosteroids, ACTH, or digitalis. Severe salt restriction is not recom-ended. Use cautiously in patients with ulcerative colitis or gallstones iliary colic may be precipitated). Bronchial asthma may occur in usceptible patients. *Adverse Reactions:* The drug is generally well lerated. The most frequent side effects are nausea, gastric irritation, miting, diarrhea, constipation, muscle cramps, headache, dizziness d acute gout. Other potential side effects include angina pectoris, xiety, depression, bradycardia and ectopic cardiac rhythms (espe-ally when used with digitalis), drowsiness, dull sensorium, hypergly-emia and glycosuria, hyperuricemia, lassitude, restlessness, transient yopia, impotence or dysuria, orthostatic hypotension which may be otentiated when chlorthalidone is combined with alcohol, barbiturates narcotics, leukopenia, aplastic anemia, skin rashes, thrombocyto-enia, agranulocytosis, nasal stuffiness, increased gastric secretions, ghtmare, purpura, urticaria, ecchymosis, weakness, uveitis, optic rophy and glaucoma, and pruritus. Eruptions and/or flushing of the in, a reversible paralysis agitans-like syndrome, blurred vision, con-nctival injection, increased susceptibility to colds, dyspnea, weight gain, decreased libido, dryness of the mouth, deafness, anorexia, and pancreatitis when epigastric pain or unexplained G.I. symptoms de-velop after prolonged administration. Jaundice, xanthopsia, paresthesia, photosensitization and necrotizing angiitis are possible. *Average Dosage:* One tablet daily with breakfast. *Availability:* Pink, single-scored tablets in bottles of 100 and 1000. (B)46-600-C

For details, please see complete prescribing information.

Regroton®

chlorthalidone 50 mg.
reserpine U.S.P. 0.25 mg.

Geigy Pharmaceuticals
Division of Geigy Chemical Corporation
Ardsley, New York 10502

RE-6742

STATE-SUN FEDERAL

Savings & Loan Association

with locations at

809 N. HOWARD ST. 728-4640

and

8200 HARFORD RD. 668-1400

MORTGAGE LOANS • CONSTRUCTION LOANS

High Quarterly Dividends: Paid March 31, June 30, September 30 and December 31

Savings Received on or Before the 10th
Receive Dividends from the 1st

Member: Federal Savings & Loan Insurance Corporation, an instrumentality of the U.S. Gov't; Federal Home Loan Bank

SAVINGS INSURED UP TO $15,000

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.

Miss Gladys Deeds
Manager

213 West Saratoga St. 727-7011

You ARE CORDIALLY INVITED TO INSPECT
THE ALL NEW PRODUCTS FROM FORD FOR 1970 AT

TOWER FORD

BALTIMORE'S LARGEST FORD DEALERSHIP CONVENIENTLY LOCATED
JUST ONE MILE EAST OF JOHNS HOPKINS MEDICAL CENTER
COMPLETELY EQUIPPED SERVICE and PARTS CENTER FEATURING OUR
ELECTRONIC DIAGNOSTIC AUTO ANALYZER
THAT PERFORMS OVER 100 SERVICE CHECKS FOR ONLY $9.95
CHOICE SELECTION OF NEW and ONE-OWNER 1969 MODELS
AT TREMENDOUS SAVINGS

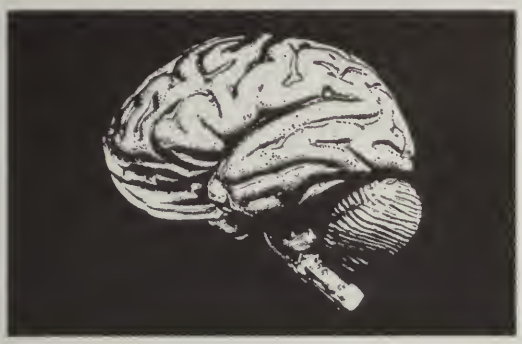
LONG TERM LEASING – DAILY & WEEKLY RENTALS



TOWER Ford

3700 E. Monument St.
675-5515 (Just East of Edison Hwy.)

New and Used Car Depts. Open Daily and Saturday 9 to 9 — Service Depts. Daily 7 to 6. Closed Sat.



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Capacity, Patient Population Size and Occupancy Rates

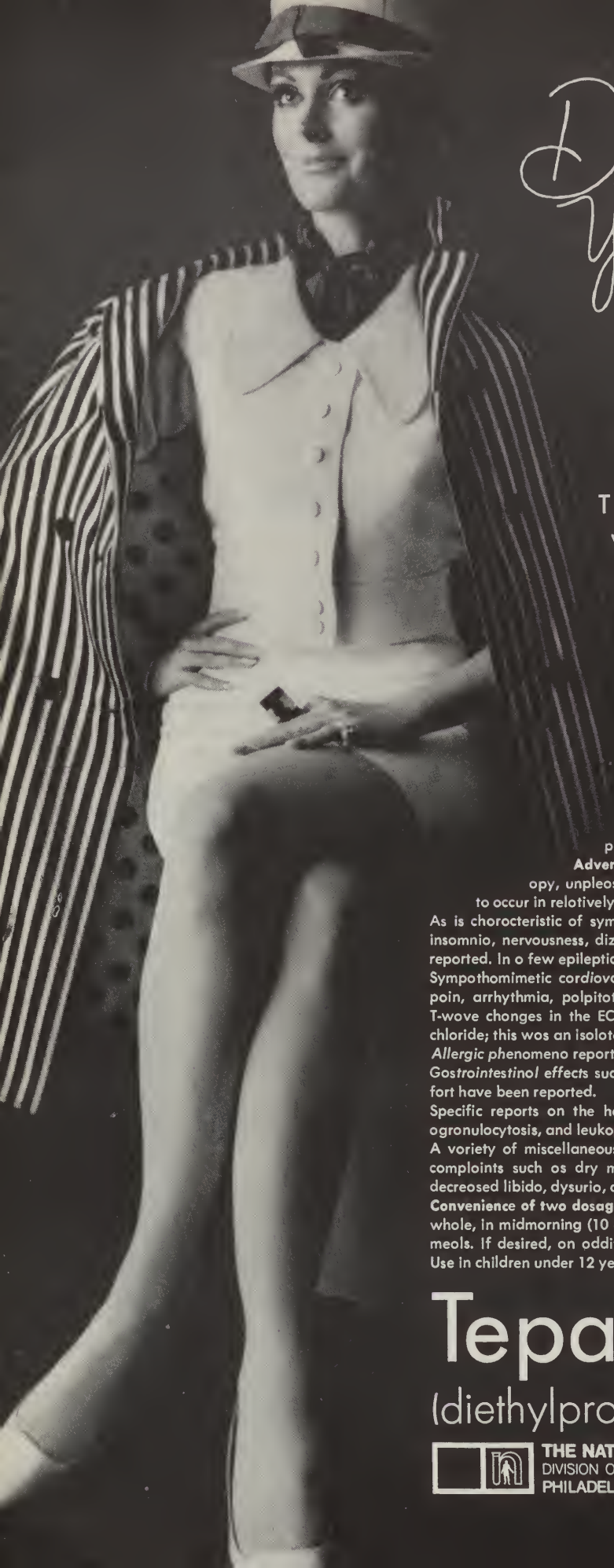
Maryland's mental hospitals last year operated at an average 104.9% capacity, while institutions for the retarded were at a 116.9% level. Comparable data based on each hospital's highest daily patient figure during the year indicate an effective overcrowding of 10.7% and 20.1%, respectively, for the two types of facilities. Statistics for the year ending June 30, 1969, are summarized in the following table.

	TOTAL	PSYCHIATRIC HOSPITALS	INSTITUTIONS FOR RETARDED
AVERAGE PATIENT POPULATION	10,541	7,451	3,090
MAXIMUM PATIENT POPULATION	11,038	7,863	3,175
CAPACITY *	9,745	7,102	2,643
OCCUPANCY RATE			
BASED ON AVERAGE POPULATION	108.2	104.9	116.9
BASED ON MAXIMUM POPULATION	113.3	110.7	120.1

** Based on American Psychiatric Association recommended 80 square feet per bed in single rooms and 70 square feet per bed in dormitory areas.*

Occupancy rates varied between hospitals and within units of the same facility. While Springfield, the state's largest hospital, continued to be most overcrowded (18.3%), virtually all operated in excess of available capacity. Only the Eastern Shore hospital at Cambridge, where the number of patients has decreased by more than one-third, had an occupancy rate of less than 90%. Maryland's psychiatric hospitals have experienced a gradual reduction in occupancy rates averaging one percent per year, primarily resulting from a decreasing patient population. However, comparable data for the two institutions for the retarded have remained virtually unchanged in recent years since new construction has barely kept pace with the increasing number of patients.

Nearly 20 years have elapsed since a series of newspaper articles on "Maryland's Shame" produced a commitment to extensive, continuing remedial actions. The current existence of substantial overcrowding, often in open wards of old and nonfunctional buildings, despite large scale construction and a decline of more than 20% in the average number of patients, should be a matter of grave concern to all state residents. It should be recognized that this chronic situation is neither conducive to effective patient treatment nor to employee morale. The Department of Health and Mental Hygiene, in order to resolve this problem and meet treatment needs most effectively, is developing a program based on the establishment and expansion of a coordinated network of community based facilities and services providing appropriate alternatives to hospitalization.



Dear Doctor, You made me what I am today— a whole lot slimmer!

TEPANIL—the right start in support of t weight-control program *you* recommend. reduces the appetite. Doesn't kill it. Weig loss is significant—gradual—yet there is relatively low incidence of CNS stimul tion. Because TEPANIL works on t appetite, not on the "nerves."

Contraindications: Concurrently with MAO inhibitors, in patie hypersensitive to this drug; in emotionolly unstoble patie susceptible to drug obuse.

Warning: Although generolly sofer than the omphetomin use with greot coution in potients with severe hypertension severe cardiovosculor diseose. Do not use during first trimester pregnoncy unless potentiol benefits outweigh potentiol risks.

Adverse Reactions: Rorely severe enough to require discontinuotion of th opy, unpleosont symptoms with diethylpropion hydrochloride hove been repor to occur in relotively low incidence.

As is chorocteristic of sympothomimetic ogents, it moy occosionolly couse *CNS effects* such insomnio, nervousness, dizziness, onxiety, ond jitteriness. In contrast, CNS depression hos b reported. In o few epileptics on increose in convulsive episodes hos been reported.

Sympothomimetic *cordiovosculor effects* reported include ones such os tochycordio, precor poin, arrhythmia, polpitotion, ond increased blood pressure. One published report descril T-wove chonges in the ECG of o healthy young mole after ingestion of diethylpropion hyc chloride; this wos an isoloted experience, which hos not been reported by others.

Allergic phenomeno reported include such conditions as rosh, urticorio, ecchymosis, ond erythen *Gostrointestinol effects* such os diarrhea, constipotion, nauseo, vomiting, ond obdominal disc fort have been reported.

Specific reports on the hemotopoietic system include two eoch of bone morrow depressi ogronulocytosis, and leukopenio.

A voriety of miscellaneous odverse reoctions hove been reported by physicions. These inclu complaints such os dry mouth, heodoche, dyspnea, menstrual upset, hoir loss, muscle po decreosed libido, dysurio, and polyuria.

Convenience of two dosage forms: TEPANIL Ten-tob tablets: One 75 mg. toblet doily, swallow whole, in midmorning (10 a.m.); TEPANIL: One 25 mg. tablet three times doily, one hour bef meols. If desired, on odditionol toblet moy be given in midevening to overcome night hung Use in children under 12 years of oge is not recommended.

Tepanil® Ten-tab®

(continuous release form)

(diethylpropion hydrochloride)

THE NATIONAL DRUG COMPANY
DIVISION OF RICHARDSON-MERRELL INC.
PHILADELPHIA, PENNSYLVANIA 19144 T-918A U.S. PATENT NO. 3,001,910 5/61



MRS. FRANK A. FARAINO, EDITOR

woman's auxiliary

Panel on "Drug Abuse" and Surprise Auxiliary Talent Highlight Semiannual Meeting

Mrs. Wallace H. Sadowsky, president, convened the semiannual meeting of the Woman's Auxiliary to the Medical and Chirurgical Faculty of the State of Maryland on September 5, 1969, in the lovely surroundings of the Hotel Hershey in Chocolate Town, USA. A silent prayer and the reading of the state auxiliary pledge set the mood for the meeting.

Greetings were extended to the ladies by John F. Schaefer, MD, Chairman of the Council of the Medical and Chirurgical Faculty of the State of Maryland. A roll call of officers, board members, and delegates followed. The minutes of the annual meeting, having been read by a reading committee, were approved and a treasurer's report heard.

The President, Mrs. Sadowsky, reported on her very busy schedule since taking office in April. She has held two meetings of the Executive Board; has attended the annual meetings and installed officers for seven of the component auxiliaries (Baltimore city, Montgomery, Prince Georges, Cecil, Harford, Washington, and Wicomico counties); has attended the annual meeting of the Woman's Auxiliary to the Student AMA and assisted in the reception following the pre-Commencement exercises of the University of Maryland Medical School; extended greetings from the Auxiliary to the Maryland Health Careers Clubs at their annual statewide meeting in Westminster; represented the Auxiliary at the Maryland Medical Association meeting in Columbia; attended the Maryland State Mental Health luncheon and meeting in Baltimore in June; attended two meetings of the Program and Planning Committee of the Med-Chi Faculty; attended out-of-state medical auxiliary meetings of the Pennsylvania Auxiliary in Hershey, Pennsylvania, New Jersey Medical Auxiliary in Atlantic City, N. J., and West Virginia Medical Auxiliary in White Sulphur Springs, W. Virginia; and attended all meetings of the 46th Annual Convention of the National Auxiliary in New York City. She has prepared and distributed workbooks for all board members, which include a calendar of events for the 1969-70 year and a directory of all component auxiliary officers and committee chairmen. She has plans to visit the Four-County Auxiliary in Oxford, the Baltimore County Auxiliary, and the Allegany County Auxiliary in the next few months. In October, she will attend the Fall Conference for presidents and presidents-elect in Chicago and the Eastern Region Workshops in Washington, D. C.

Each county president reported on her local program for the year, and reports on the progress of AMA-ERF and Community Service projects were heard. Mrs. Elmer G. Linhardt, chairman for AMA-ERF, announced that AMA-ERF Fun(d) Day at the Races would be held again at Laurel Race Track on November 12, 1969. Mrs. G. Allen Moulton distributed brochures she had prepared on the resources for community service available through the ten package programs supplied by the Woman's Auxiliary to the American Medical Association.

A nominating committee, consisting of the following members, was elected: Mrs. George S. Malouf, chairman; Mrs. Charles Bagley, Mrs. Ferdinand Kadan, Mrs. William Holbrook, and Mrs. James Banks.

Following adjournment of the business meeting, the auxiliary membership joined the Faculty at an excellent panel on "Drug Abuse," highlighted by the

facts presented by Harvey Gollance, MD, of New York City, Administrator of the Methadone Maintenance Treatment Program, and Steven V. Sklar, Delegate to the General Assembly of Maryland from the 5th Legislative District, Baltimore city.

During the next two days, members of the Auxiliary joined the Faculty on tours of the new and fabulous Hershey Medical Center, the Amish country, or the Chocolate Factory.

The final dinner on Saturday evening concluded with a surprise talent show presented by Auxiliary members. Mrs. Richard Bauer was mistress of ceremonies and presented Mrs. Elmer Linhardt and Miss Angela Linhardt, pianist, in a "Musical Salute to the Medical Profession." This was followed by a "Salute to Hershey," written and portrayed by Richard Bauer, MD, who received audience assistance in musically bemoaning "Doctor O'Donnell's falling into the chocolate vat." The "Wicomico Kickers," Mrs. Raymond Yow, Mrs. Connie Galton, and Miss Barbara Laughlin, gave a Can-Can performance to rival the best. Vocal honors went to the "Washington Warblers" and the "Harmonizing Honeydrops": Mrs. Howard Weeks, Mrs. H. Leonard Warres, Mrs. Henry P. Laughlin, and Misses Phyllis and Barbara Bauer. The evening concluded with a hilarious "Knobby Knees Contest," won by Dr. Bauer, whose prize was a three-pound Hershey chocolate bar!!!

attention doctors--

When you guard the health of your funds by investing them where they are safe and accessible, you're practicing preventive medicine against inflation. And, funds grow at a gratifying rate through DAILY compounding of dividends.

5.23%

ON PASSBOOK ACCOUNTS

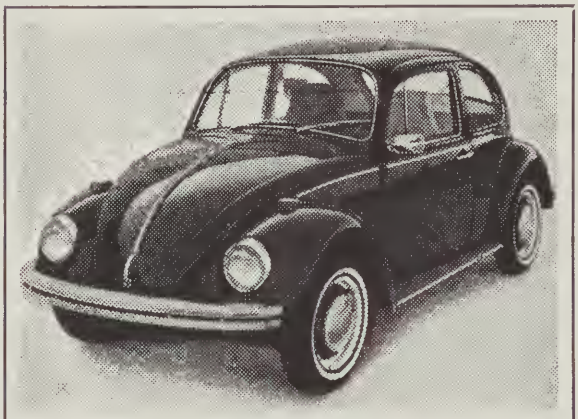
Effective Annual Yield

Compounded & Computed **DAILY**

Guaranteed Protection

Accounts insured up to $20,000 by the Maryland Savings Share Insurance Corp.

SECURITY
Savings & Loan
(a stock corporation) Organized 1895
Downtown—24 E. Fayette St.
Branch—Security Shopping Center



Live below your means

If you'd like to get around the high cost of living, we have a suggestion.
Cut down on the high cost of getting around. And buy a Volkswagen. It's only **$1839***

*Suggested retail price east coast P.O.E. Local taxes and other dealer delivery charges, if any, additional.

MARYLAND VOLKSWAGEN
1212 E. 25th St.
(corner of Harford Rd.)
BALTIMORE, MD. Phone 889-7616

The Robert Morris Inn — 1710
ON THE SCENIC TRED AVON RIVER, OXFORD, MD.



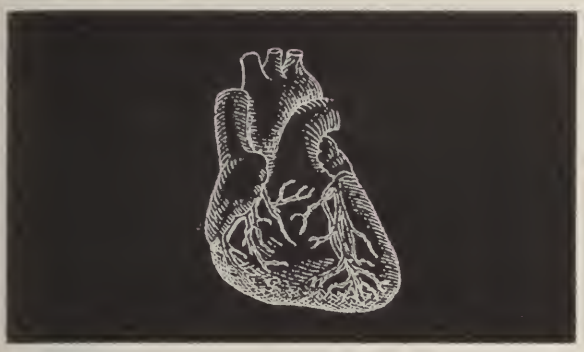
Dinner—5:30 to 10 P.M. Lunch—11:30 A.M. to 2:30 P.M. Sunday Dinner—1:30 to 9 P.M.

Duck and Goose Season—October 31 thru January 15. The most complete hunting package on the Eastern Shore.

DINING ROOM
TAP ROOM
TAVERN
PACKAGE LIQUOR
ROOMS

Visit Us Soon

OXFORD,
MARYLAND
CA 6-5111



JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Reasons for Renal Allograft Success As Compared To Heart Transplants

Robert M. Ollodart, MD
Assistant Professor of Surgery
University of Maryland School of Medicine

Clinical renal allografting has become a complicated, yet successful treatment for end stage kidney failure, while cardiac transplantation remains a clinical experiment. Although renal allografts have been performed for over 12 years, the experience gained fails to fully explain the difference in results with the two types of transplants. Renal transplants are more often successful because they have several advantages over cardiac transplants. In renal transplants, tissue typing can be used to select donors, artificial supportive techniques (dialysis) can substitute for the kidney's functions while a donor is being selected and during rejection crises, and rejection is more easily diagnosed at a time when reversal with immunosuppressive drugs is still possible.

Tissue Typing

There are two major histocompatibility systems in the human: the HLA (Human Lymphocyte Antigen) system and the ABO blood group system. HLA antigens are found on virtually all nucleated cells as well as platelets, and A and B antigens are found not only on red cells, but essentially all other body cells. ABO matching is accomplished by red cell typing. HLA matching involves identification of HLA antigens (at least ten of which are well defined and another eight poorly defined) on the surface of lymphocytes by the cytotoxic or agglutinating effect of typing sera. These sera are obtained from multiparous women who become sensitized to fetal HLA antigens they do not possess, patients who have become sensitized by multiple transfusions (containing lymphocytes), and patients who have rejected allografts and have not been re-transplanted.

HLA antigens are inherited through closely linked genes on a single chromosome. This arrangement allows family genotyping to be made. Parents (genotype AB and CD) give one chromosome to each child so that four sibling genotypes (AC, AD, BC, BD) occur equally. A child who needs a kidney may be any one of these and has a 25% chance of sharing both parental chromosomes with another sibling (HLA identical), a 50% chance to share one (one allele difference), and a 25% chance to share none (two allele difference). Parents must be one allele different than their children. Grafts between an HLA identical donor and recipient have an excellent prognosis since only minor histocompatibility loci difference must be dealt with by immunosuppression.

Such matches usually have no major rejection crises, usually require lower drug dosage, and have four-year survival rates of close to 90% in some series. One allele difference grafts show a 70%-80% four-year survival and two allele difference grafts are comparable to unrelated cadaveric transplants (20%-50% survival). Paired organs and dialysis allow the best living related donor to be chosen and prepared for transplantation. Cardiac donors are non-related.

Cadaveric donor selection for both renal and cardiac transplants relies on choosing the donor with the least number of mismatches. While this is definitely advantageous, the individual case may belie the typing outcome. Not all antigens are measured and serious mismatches may go undetected, contributing to irreversible rejection in the face of "a good match." In cardiac patients, the inability to keep patients alive while a poor match is refused and a better one awaited further restricts advantages available through typing.

Diagnosing Rejection

Reversal of organ rejection depends in part on early diagnosis. Rejection symptoms such as enlargement and tenderness of the easily palpated renal transplant, fever, leukocytosis, decreased urinary output, rise in blood pressure, elevated BUN and creatinine usually occur in time to increase the steroids or antilymphocyte globulin or both, and save the graft. Cardiac rejection often goes undetected until the resulting functional impairment eventually causes the patient's death. Voltage changes on the EKG have not been reliable indicators of rejection in man or animals. Better methods of diagnosing rejection are needed for all organ transplantation, but most particularly for cardiac transplantation.

Functional Support of the Patient

Many renal rejection crises are accompanied by anuria for a certain period, during which hemodialysis supports the patient. Such crises may last many days before reversal occurs. Cardiac patients have no adequate support during this period. While nephrologists have witnessed the successful use of "artificial kidneys" and organ transplants in treating their patients, cardiologists await the development of circulatory assist devices for similar success.

The development of specific immunological tolerance to histocompatibility antigens is needed to produce further advances in all organ transplantation. Recent isolation of such antigens and some success in producing their specific tolerance indicate a rapidly approaching era when the dangerous immunosuppressive drugs now used will not be necessary. Organs capable of being transplanted but usually rejected (heart, lung, and liver), will then remain while their new host may still repulse infectious organisms.

SKIN PROBLEMS

Caused by itching due to:



Dry Eczema	Acne
Chafing	Ivy Poisoning
Minor Burns	Cold Sores
Athlete's Foot	Heat Rash
Dry Skin	Diaper Rash
Wind Burn	Chapping
Insect Stings	Hemorrhoids

For Safe, Sure, Speedy Relief — — Get RESINOL GREASELESS!

Medical Scientists have conquered 6 dread diseases in the past decade, but they are largely in the dark, they admit, in finding relief for one age-old ailment—itching



New remedies containing antibiotics have been tested, but have often caused side effects which are worse than itching skin. After many years of research and testing, Resinol Greaseless Cream was developed. . . . A doctor's formula containing safe yet powerful ingredients, Resinol Greaseless contains an amazing, proven "anti-itch" medication called Resorcin, which quickly and effectively relieves most any kind of itching. Try Resinol Greaseless . . . You'll be delighted to find that it really works! At all drug stores. Buy a tube today.

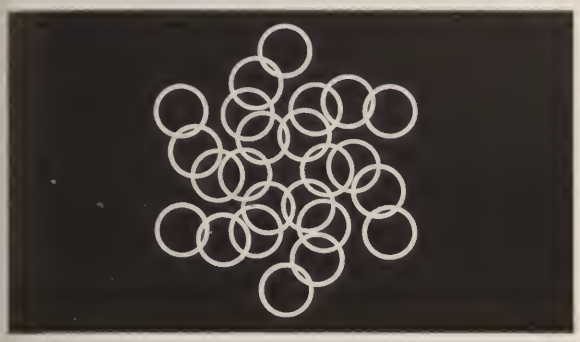
Family First Aid in a Tube Carry in Purse or Pocket A Medicine Cabinet "Must"

"Resinol Really Works"

RESINOL CHEMICAL COMPANY

517 W. Lombard St.

Baltimore, Md. 21201



From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

alcoholism section

A Man Named Tufti

Some Thoughts on Police Officers, Diabetics, and Alcoholics

IRVING B. ZEICHNER
Chief, Legal Research
Administrative Office of the Courts in New Jersey
Former Judge of the Atlantic Highlands Municipal Court

This is the text of a talk presented by Judge Zeichner before the Monmouth County Safety Council at The Ferry, Brielle, N.J., on January 16, 1969. Reprinted by permission of Public Health News, *New Jersey State Department of Health, March 1969.*

I welcome this opportunity to talk to public-spirited people who find time for the kind of community service that usually attracts little attention. What I want to discuss is something most unusual that happened to a man nobody knows—a man named Tufti.[1]

Mr. Tufti was a diabetic who required medication to control that disability. Moreover, he was required to eat at scheduled intervals to attain a balance between medication and food. One day he went fishing. He took his boat for a spin in Puget Sound near Tacoma, Washington. He had his medication and he had eaten breakfast. The time was 9 AM, and it was necessary that he eat again promptly at noon. So he fished until 11 AM, and secured the boat. This is the last thing he remembered until he awoke much later in the drunk tank at the Tacoma city jail. What had happened?

At 2:24 PM, the police, in response to a call, found Mr. Tufti slumped over the wheel of a small foreign automobile, facing the wrong direction on a one-way street. The officers checked the man's pulse, shook him awake, and helped him out of the car. They thought that he smelled of alcohol, and his eyes were bloodshot. His walk was unsteady and his speech slurred. Thus satisfied, the officers placed him in the back of the patrol car where he answered their questions, but failed to tell them of his diabetic condition. However, after considerable effort, he did produce a wallet containing his driver's license. It also contained a card which stated: "I am a diabetic. I am not intoxicated." Since the officers did not see the card, they concluded that Mr. Tufti was drunk and impounded his vehicle. He was taken to the city jail where he was charged with being drunk in an auto.

At the jail, Mr. Tufti was booked and searched. The contents of his pockets were removed, as was the money from his wallet. The time was approximately 3 PM. Mr. Tufti, apparently asleep, was left on the drunk tank floor.

Meanwhile, back at home, Mrs. Tufti became alarmed when her husband failed to return for lunch. She checked at the boat mooring and contacted the police. She informed them that she feared her husband was in insulin shock and gave them a description of the car and its license number. Mrs. Tufti also called the family physician. He in turn notified the police to watch for Mr. Tufti, who could be slumped over the wheel of his car in a state of shock.

Back at the drunk tank in the city jail, Mr. Tufti remained unconscious until about 3 AM the following morning. When he regained consciousness and discovered where he was, he called the officers. He

1. Plaintiff in Tufti v. City of Tacoma, 431 P.2d 183 (1968). The sequence of events is taken almost verbatim from the opinion.

was allowed to bail himself out for $35. He was released and given a bag containing his possessions, including his sugar, saccharine tablets, billfold, and driver's license. It also contained his diabetic card. Mr. Tufti ate some sugar lumps and called his wife.

Mrs. Tufti found her husband on the street in a dazed condition. She complained to the chief of police and, after an investigation, the drunk charge was dropped. A charge of negligent driving was substituted and later dismissed. Mr. Tufti immediately sued the city of Tacoma and its police chief for false arrest and imprisonment.

At the trial, the chief testified that all officers are trained to detect the symptoms of a diabetic and to check for such signs when a person is arrested on drunken charges. He stated that the department followed the established policy of holding all intoxicated persons for four hours. The jailer testified that if someone who is jailed appears to be ill —"even so much as a bad cold," the jail is obligated to send him to a facility for care. The suit against the chief of police was dismissed. But a judgment was entered against the city, and in favor of Mr. Tufti.

The Supreme Court of Washington affirmed the liability of the city on the grounds that even though Mr. Tufti appeared to be drunk, there was no justification for holding him. In fact, he should have been released and given immediate care.

Courts seldom fail to blame the city for negligence resulting from lack of police training. In the leading case of McAndrew v. Mularchuk,[2] a reserve policeman who had been assigned to special duty at a tavern accidentally shot a minor who was either coming toward him or running from him—depending on whose testimony you believed. The New Jersey Supreme Court held that the Borough of Keansburg was subject to damages for the minor's injuries if the police chief had assigned an officer to duty without giving him proper training in the use of firearms.

If lawsuits are to be avoided and, more important, if lives are to be saved, it is incumbent upon municipalities to train all officers to distinguish between a diabetic and an alcoholic. Those not trained to detect the signs of insulin shock can easily label the diabetic as a drunk. There is the same staggered walk, slurred speech, dilation of pupils, disorientation, and even loss of memory.

The diabetic should wear the Medic Alert bracelet identifying his condition. This is a wise precaution for anyone with a hidden medical problem that should be known in case of an emergency.

But what if Mr. Tufti had indeed been alcoholic instead of diabetic? There is little disagreement that alcoholism, as a chronic disease or behavior disorder, is a major public health problem in this nation.

Some studies show that there are as many as 7 million alcoholics and half as many additional problem drinkers in this country. In fact, the use of alcohol is so widespread that it is extremely difficult to enact or enforce effective laws governing its use and abuse. One result is that alcohol contributes to, or is associated with, at least half of our fatal traffic accidents. Many other crimes, such as homicide, are usually alcohol-related.

Even more startling, perhaps, is the report of the President's Crime Commission [3] stating that one of every three arrests in the United States is for public drunkenness. Two million annual arrests for this offense clog the courts, crowd the jails, and overburden the police department.

Of the two million annual drunk arrests, many of those arrested are chronic offenders. Despite the fact that drunkenness is not a crime, a substantial number of alcoholics with histories of prior arrests have served long terms behind bars. Most repeaters live and die on "skid row," well described as the dilapidated urban area where "substandard hotels and rooming houses are intermingled with numerous taverns, pawn shops, cheap cafeterias, employment agencies that specialize in jobs for the unskilled, and religious missions that provide free meals after services."

The police do not arrest all drunken persons: some are assisted to their houses. Only when he appears to have no home or family is a person most likely to be arrested and taken to jail. Perhaps he will be permitted to sleep it off in the tank, a barren cell holding one or two prisoners, or as many as 200. Sometimes there is not room to sit or lie down. Although the tank is certainly not a hospital, perhaps it should be, since a chronic alcoholic generally suffers from a variety of ailments and is often in danger of contracting serious medical complications.

As long as a defendant is serving his sentence, he is fed and sheltered. When his time is up, he is likely to return to his former environment, with no job, no money, and no plans. He is frequently arrested again within a matter of days or even hours. This seems to indicate that our criminal justice system is ineffectual in deterring drunkenness, or in meeting the problems of the chronic alcoholic. However, the system does remove the drunk from public view and provides him with a brief period of forced sobriety. But the system cannot meet his underlying medical and social problems.

If, as some people suggest, alcoholism is not a crime but a disease, why are so many people being needless-

2. 162 A.2d 820 (1960).

3. The Challenge of Crime in a Free Society (1967).

ly jailed? The United States Supreme Court recently faced this question in a test case.

A 67-year-old bootblack named Powell was charged with public intoxication, thus violating the Texas penal code. Psychiatrists testified that the defendant, who had been jailed on intoxication charges at least 73 times over a period of years, was a chronic alcoholic. The defense maintained that to convict a chronic alcoholic and sentence him to such cruel punishment as jail violated the Eighth Amendment to the Constitution.

The Supreme Court upheld the conviction of the chronic alcoholic: ". . . Facilities for the attempted treatment of indigent alcoholics are woefully lacking throughout this country. It would be tragic to release large numbers of helpless, sometimes dangerous and frequently unsanitary inebriates to the streets of our cities, without even the opportunity to sober up adequatcly which a brief jail term provides . . . Yet the medical profession cannot and does not tell us with any assurance that, even if the building, equipment and trained personnel were made available, it could provide anything more than slightly higher class jails for our indigent habitual inebriates." [4]

In inferior jails, the term served for drunkenness is short. But with a civil commitment, the term is "until cured," giving the prisoner no hope of receiving effective treatment and with no prospect of periodic freedom. What should be done to improve the present situation? Perhaps the drunkenness statutes should be repealed. But the President's Crime Commission recommended that disorderly and other criminal conduct accompanied by drunkenness should remain punishable as separate crimes. The Commission also suggested that there ought to be detoxification stations, as part of comprehensive treatment programs with extended after-care facilities. It was also suggested that there be routine medical evaluation of all individuals suspected of intoxication and taken into custody by the police, and routine training of police officers in handling public intoxication cases.

Research into alcoholism, the problems of alcoholics, and methods of treatment, would save $2 billion lost to industry each year due to the alcoholic problems of employees. Such research would save lives—not only the lives of alcoholics, but of the non-alcoholics, such as Mr. Tufti. It might even avoid lawsuits. These recommendations ought to be argued, debated, and discussed. The public cannot be expected to respect a system of public health or criminal justice that discards people or deposits them in jail because they are sick, whether diabetic or alcoholic.

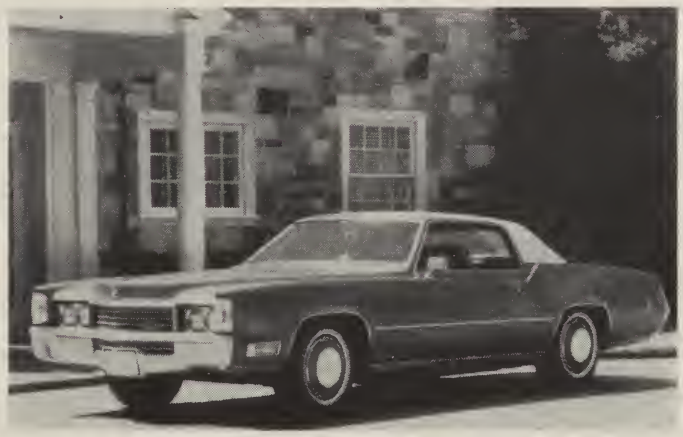
4. Powell vs. Texas, 392 U.S. 514 (1968).

HIS PERSONAL CAR – *For the Professional Man*

– AND FOR HER . . .

— its mate as a Christmas Surprise!

The ultimate in beauty, luxury and performance. The 1970 Fleetwood Eldorado retains the classic look of its predecessors while highlighting changes in the grille, lighting and side molding. BUT the big story is under the hood, with the new 500 Cu. in. engine that produces 400 horsepower with 550 ft. lbs. of torque—the largest production passenger car engine in the world!



SWARTZ CADILLAC CO.

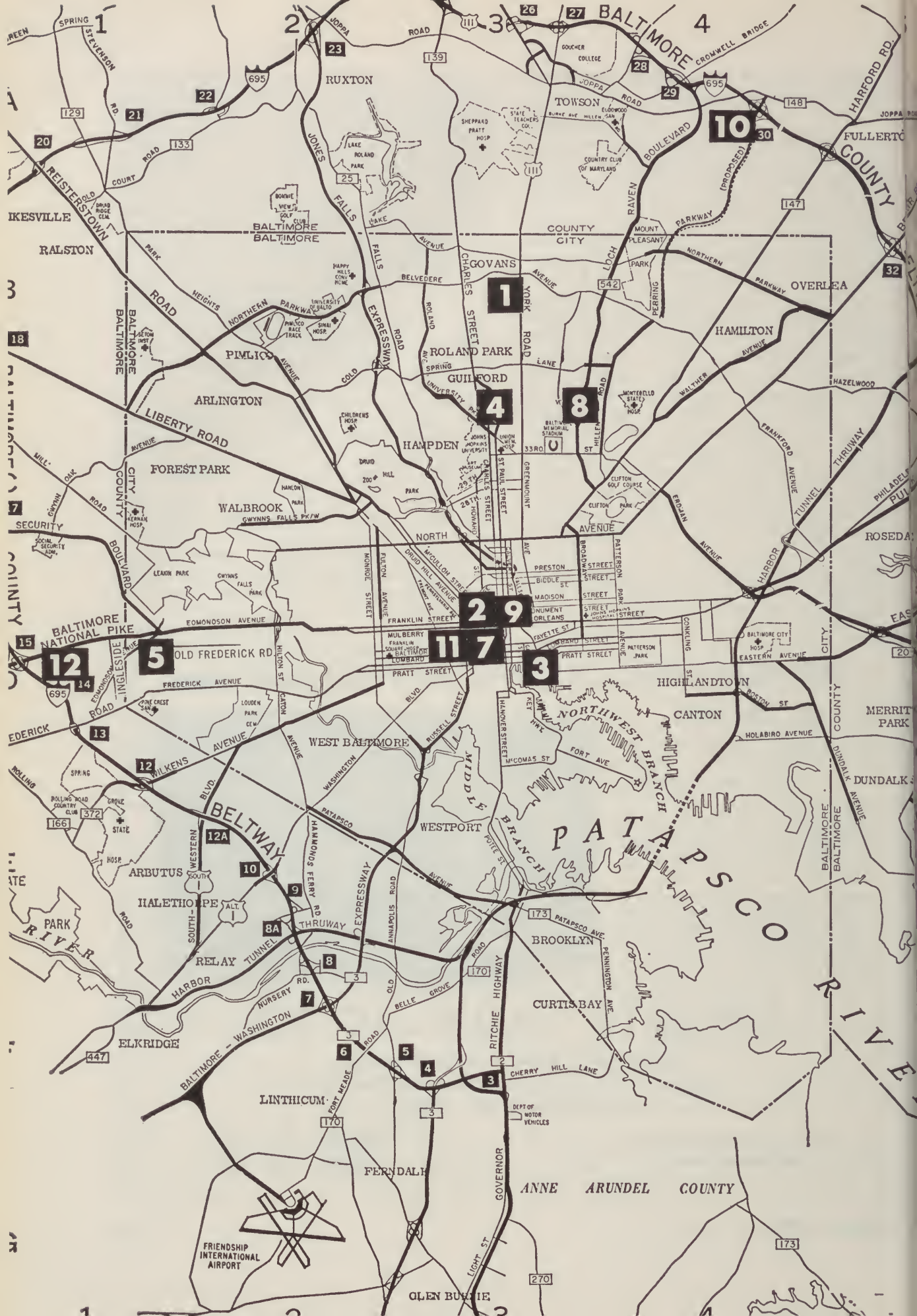
Authorized-Franchised Cadillac Dealer

Factory-trained mechanical and Body Shop personnel

CAR LEASING AND DAILY RENTALS

5323 Reisterstown Road
BALTIMORE, MD.

PHONE 664-3500
PHONE 664-9963


BALTIMORE
RUXTON
TOWSON
GOVANS
ROLAND PARK
GUILFORD
HAMPDEN
ARLINGTON
PIMLICO
FOREST PARK
WALBROOK
NORTH
OVERLEA
HAMILTON
FULLERTON
HIGHLANDTOWN
CANTON
MERRITT PARK
DUNDALK
WEST BALTIMORE
WESTPORT
BROOKLYN
CURTIS BAY
ARBUTUS
HALETHORPE
RELAY
ELKRIDGE
LINTHICUM
FERNDALE
GLEN BURNIE
PATAPSCO RIVER
NORTHWEST BRANCH
MIDDLE BRANCH
PATAPSCO BRANCH
ANNE ARUNDEL COUNTY
BALTIMORE COUNTY
BELTWAY
FRIENDSHIP INTERNATIONAL AIRPORT
LIBERTY ROAD
BALTIMORE NATIONAL PIKE
OLD FREDERICK RD.
HARBOR TUNNEL THRUWAY
BALTIMORE - WASHINGTON BLVD.
CHARLES STREET
YORK ROAD
JONES FALLS EXPRESSWAY
HARFORD RD.
COUNTY CITY
MOUNT PLEASANT PARK
LOCH RAVEN BOULEVARD
NORTHERN PARKWAY
FRANKFORD AVENUE
HAZELWOOD
ROSEDALE
EASTERN AVENUE
HOLABIRD AVENUE
BOSTON ST.
PATAPSCO AVE.
CHERRY HILL LANE
PENNINGTON AVE.
RITCHIE HIGHWAY
GOVERNOR
LIGHT ST.
FORT MEADE ROAD
ANNAPOLIS ROAD
OLD BELLE GROVE ROAD
HAMMONDS FERRY RD.
SOUTH-WESTERN
WILKENS AVENUE
FREDERICK AVENUE
EDMONDSON AVENUE
GWYNN OAK
SECURITY BOULEVARD
REISTERSTOWN ROAD
JOPPA ROAD
COLD SPRING LANE
PIMLICO RACE TRACK
SHEPPARD PRATT HOSP.
JOHNS HOPKINS HOSP.
UNIVERSITY OF BALTO.
MERCY HOSP.
SINAI HOSP.
CHILDRENS HOSP.
UNION MEM. HOSP.
MONTEBELLO STATE HOSP.
KERNAN HOSP.
BALTIMORE CITY HOSP.
EASTERN
SOCIAL SECURITY ADM.
DEPT OF MOTOR VEHICLES
COUNTRY CLUB OF MARYLAND
CLIFTON GOLF COURSE
BALTIMORE MEMORIAL STADIUM
PATTERSON PARK
DRUID HILL PARK
LEAKIN PARK
GWYNNS FALLS PARK
LAKE ROLAND PARK
CLIFTON PARK
HANLON PARK
LOUDEN PARK CEM.
PINE CREST SCH.
ROLLING ROAD COUNTRY CLUB
STATE TEACHERS COL.
GOUCHER COLLEGE
BONNIE VIEW G.C.
BROAD RIDGE CEM.
LAKE ROLAND
PRESTON STREET
BIDDLE ST.
MADISON STREET
MONUMENT STREET
ORLEANS STREET
FRANKLIN STREET
MULBERRY STREET
LOMBARD STREET
PRATT STREET
FAYETTE ST.
BALTIMORE STREET
CHARLES STREET
ST. PAUL STREET
GREENMOUNT AVE.
MONROE STREET
FULTON AVENUE
PRESIDENT STREET
HILTON ST.
CATON AVENUE
RUSSELL STREET
HANOVER STREET
McCOMAS ST.
FORT AVE.
POTEE ST.
WASHINGTON BLVD.
PATAPSCO AVENUE
MONUMENT STREET
BROADWAY STREET
PATTERSON PARK AVENUE
CONKLING ST.
FRANKLIN SQUARE HOSP.
JOHNS HOPKINS HOSPITAL
PENN STATION
MARC
LIGHT RAIL
METRO
1
2
3
4
5
6
7
8
9
10
11
12
12A
13
14
15
18
20
22
23
25
26
27
28
29
30
32
2 9
11 7
12 14
10 30
8A
695
129
133
139
147
148
166
170
173
270
372
447
542

Restaurants of Distinction

Locations indicated by numbers on map



Westview Lounge & Supper Club

DANCING NIGHTLY • LUNCHES & DINNERS

Finest Sea Foods
Prime Meats

5653 Old Frederick Road

East of Ingleside Ave., off Baltimore National Pike

D KUCHTA, Manager

Phone 744-0223

THE ORIGINAL

Maria's "300"

33 YEARS SAME LOCATION

altimore's Finest Italian Restaurant

THE LEISURE COCKTAIL LOUNGE

5 minutes from Baltimore Civic Center

Open 12 noon to 3 A.M.—Closed Mondays

For Reservations Call 685-2811

2 blocks south of the Flag House

300 ALBEMARLE STREET

Tijuana Tacos

Fine Mexican Food

5847 YORK ROAD

cktails Mexican Beers

Tuesday thru Sunday

Open 5:00 P.M.---12:00 P.M.

Dinner and Snacks

Closed Monday

Phone 435-9858

Cork 'n Bottle Restaurant

EAK – SEAFOOD – PRIME RIB

COCKTAILS

LUNCHEON – DINNER

ajor Credit Private

rds Honored Party Rooms

E. FAYETTE ST. BALTIMORE, MD.

½ Block from Charles Center

539-1268

6

MILTON INN

Circa 1740

Dine Amid Early American Charm
Warm, Gracious and Inviting

Selected By Life & Time Magazines as One of America's Finest Inns

Lounge & Dining Room Available for Private Parties

ATTILIO ALLORI, Owner

3 Mi. North of Cockeysville on York Rd.

SPARKS 771-4366

Fine Restaurants

Recommended for

Your Dining Pleasure

7

Miller Bros.

"The Place to Eat"

NATIONALLY FAMOUS

AFTER THE SHOW . . . Just across the street from Mechanic's Theatre in the new Statler Hilton Hotel. Open for luncheon, dinner, and after-theatre suppers . . . until midnite. Cocktail Lounge (with piano bar) open 'til 2 A.M.

For reservations call **752-4822**

2

WHITE RICE INN

Chinese-American Restaurant

320 PARK AVENUE

Baltimore 1, Md. MU 5-6790

CARRY-OUT SERVICE

SPECIAL LUNCHEON and DINNERS

PRIVATE DINING ROOM FOR PARTIES

Open Daily 11 A.M. to 3 A.M.

Sunday 12 Noon to 3 A.M.

---

11 *Downtown Baltimore's most renowned Italian cuisine*

PALMER HOUSE

106-108 N. EUTAW ST.

- *Cocktail Lounge*
- *Luncheon*
- *Dinner*



Your Host
Tom d'Anna

539-9021

10



SPECIAL AT THE

FABULOUS CLUB VENUS

An Evening for Two . . Only $15

Offer good every night except Saturday
Make Reservations Now

Perring Plaza Shopping Center—Beltway Exit 30

For Reservations Call NO 8-2232

8

The Hecht Co.

NORTHWOOD SHOPPING CENTER

ROOFTOP RESTAURANT

Phone 433-8018

4

Broadview Restaurant

Cocktails • Dinners • Luncheons

Private Entertaining Facilities

116 W. University Parkway at 39th St.

CALL CH 3-1216

Hoechst is proud to be able to offer
nearly 100 years of patient-centered research
to "bridge" the sometimes awesome chasms of medicine.



*"Life is short and art is long;
the crisis is fleeting,
experiment risky,
decision difficult."*

HOECHST PHARMACEUTICAL COMPANY, Cincinnati, Ohio 45229
Division of American Hoechst Corp.

HOECHST

Major discoveries of Hoechst world-wide research include procaine, arsphenamine, mersalyl, tolbutamide, and furosemide.



DOUGLAS G. CARROLL, MD, EDITOR

Part II: Spinal Cord Injuries

In no medical condition is the gap between theoretical and applied knowledge greater than in the treatment of cord injuries. We know how these patients should be treated; we are generally unable to apply what we know.

1. We know, for example, that the patient must be turned frequently and kept dry to prevent decubitus ulcers. The facts are that few patients complete their first month without developing major ulcers.

2. We know that a coordinated program integrating the efforts of the neurosurgeon, orthopedic surgeon, urologist, physiatrist, and psychiatrist is essential in the early care of the patient. It is rare indeed that an ideal program is carried through without a breakdown or delay in the coordination of these specialists.

3. We know that continuity of care under a single doctor is the best plan for long term care. Rarely is a patient with complete cord severance able to find a single doctor or even a single hospital to turn to throughout his life.

The following case was presented at a student conference held at the Baltimore City Hospital (BCH) to focus attention on some of the management problems of patients with chronic diseases. The conference was held six months after the patient's admission to the BCH for an epidural abscess.

Student: This is the first BCH admission for Mr. S. (BCH # 452934), 24 year-old mechanic, who complained of having weakness of the lower extremities for 12 hours. One year prior to admission he suffered a "whip-lash" injury to his neck, and wore a brace for several months. Eighteen days prior to admission, he noticed a boil on his right elbow. His wife put some black "drawing" salve on it, and it drained. However, his arm became sore, and 16 days prior to admission to BCH, he reported to that hospital's emergency room. At this time the boil was debrided and cultured (staphylococcus aureus, coagulase positive). The patient was given penicillin and streptomycin and told to return for further examination. He reported back twice, and the lesion healed completely.

Ten days before admission to the hospital he began to have continuous dizziness, and pain in the chest and back. He received some pills for pain from his doctor, who recommended that he go to the emergency room of a local hospital. He did not follow his doctor's suggestion. On the day of admission, the pain in his chest and arms returned, his legs became numb, and by afternoon he had total paralysis of both legs.

Doctor: Could you tell us something about the pain in your chest?

Mr. S.: It was like a sharp pulling, someone sticking me in the back.

Doctor: Did it stay in one place?

Mr. S.: It came around the sides when I moved my arms.

Doctor: How come you didn't go to the hospital after your doctor suggested that you go?

Mr. S.: Well, I told my wife I would wait. It didn't really bother me because I didn't have any pain. I told my wife I couldn't move my legs, and she didn't believe me at first.

Student: Admitted to the hospital, the patient was examined. His rectal temperature was 102°, the pulse 90, respiration 20, and the B.P. 110/70. He was able to move only his arms and head. On the neurological examination, the patient was well oriented. The cranial nerves were intact. The neck was stiff. He had dysesthesia below T8 and hypesthesia from L1 to S3. Vibration sense was intact in the lower extremities. Temperature and position sense were lost in the lower extremities. A diagnosis of epidural abscess was made.

Laboratory findings were normal except a white cell count of 36,000. On the lumbar puncture, the opening pressure was 130, closing pressure 80. The fluid was slightly xanthochromic; Pandy 3+. There were no cells, and glucose was 22 mg%.

A myelogram was done which did show complete block at the level of T6-7. He was taken to the operating room, and a laminectomy was performed. Five cc of yellow pus grew coagulase positive staphylococcus aureus. The organism was sensitive to penicillin and the patient was started on a high dose of that drug. Over the next few days there was gradual return of sensation.

Doctor: Can you tell how he has been in the six months since surgery?

Student: He has had quite a bit of trouble with urinary tract infections. Now he is very much better. He has been on physical therapy for six months, and he is coming along quite well. He has returned home three weekends now, and he is able to walk on crutches and walk a little without crutches. He had leg weakness, increased tone, and mild knee flexion contractures.

Doctor: Let's take a look at him now. His arms are all right. He has a little clonus when he stands or puts weight on his legs. Let's have him walk. Keep your head up when you walk. Can you tell where your feet are?

Mr. S.: They feel a little stiff and swollen.

Doctor: He is using a four point gait with crutches. He can also walk with a walker, but he prefers crutches. I would like to ask you just a few questions before you go. How do you think this difficulty you have walking is going to effect what you do in the future?

Mr. S.: Well, the type of work I am doing, it is going to be hard to say. If I can get to where I can bend over again and get my legs straightened out, I'll be all right.

Doctor: Is there any other kind of work you could do?

Mr. S.: Well, I fooled with radios and stuff like that. I never really had any training for it.

Doctor: Your possibility might be some kind of radio repair, TV repair if you couldn't do automobile mechanical work. That's what you've been doing.

Mr. S.: That's what I've been doing, yes.

Doctor: What bothers you most now?

Mr. S.: Well, right now it is the shaking in this leg.

Question from audience: What do you do when you get discouraged?

Mr. S.: Just keep going. There for awhile I was ready to give up. Then I found I could get on crutches and now I am all right.

Doctor: Why were you ready to give up?

Mr. S.: Well, I just didn't think I had it in me, you know, to keep going.

Question from audience: Mr. S., has your social worker helped you?

Mr. S.: She has helped me a good bit, but they changed them around, different ones.

Question from audience: What is she doing for you now?

Mr. S.: Well, she helped my wife get straightened out on a lot of things for me as far as that goes.

Doctor: O.K., thank you for talking with us. (Patient leaves.)

Student: Well, he did have some financial problems. This bothered him somewhat. I think this may have contributed to his depression. His wife and three children, aged 8 months to 4 years old, are here in Baltimore and living with her mother. Evidently they didn't have any support, and so it was necessary to contact the welfare to see if they could be taken care of somehow. And they also hadn't been able to come in to visit him. I think there was a transportation problem, and I think that was taken care of through the social worker. So that helped quite a bit. I also think that his trips home on weekends did help to lift his spirits a little bit.

Doctor: So this patient, besides the physical problem, did have very significant emotional and social problems, which hopefully, at least for the time being, have been solved to some extent.

Student: I think so. He carries on an industry here in the hospital. I noticed last night he had a set of tools he had been carrying around in the wheelchair, and he has also been carrying around a radio for someone that needs repairing.

Doctor: We have shown this patient for several reasons. The first is to stress the importance of making an early diagnosis of epidural abscess. There are four stages to this disease that are well illustrated in this patient. First, he had a documented staphylococcus furunculosis. This was treated very well. It was drained, and he was given high doses of penicillin and streptomycin. He then developed back pain, was seen by a doctor, and given more penicillin. If the patient is examined at this second stage, an area of tenderness or swelling over the back where there is an abscess may be found. Next, if not treated then, the patient may develop pain around the chest or in the abdomen where the abscess is pressing on a root. Finally, the cord itself is affected, and the patient develops paralysis. In the management of this patient, a number of things went wrong. First, he went from doctor, to emergency room, to doctor, and no single physician knew just exactly what was going on. Secondly, he delayed coming to the hospital after he developed paralysis of the legs, and one wonders just what this means in terms of his intellectual and emotional pattern. Was he just so stupid that he didn't know that paralysis of the legs is a bad thing, or was he so scared that he was afraid to come to the hospital?

When he got into the hospital, an immediate diagnosis was made. Every minute counts with an epidural abscess. It is not a common condition, but it is one any doctor may see; it is curable if recognized early enough.

This man has been extremely fortunate. Three weeks after admission, he was completely paralyzed in his legs, and furthermore, he developed ulcers over his trochanter. Since three weeks had gone by with no return of function, the outlook was poor. However, since then he has gradually improved.

Psychiatrist: Another important feature is the patient's emotional reaction to his disease. It was very important for him to maintain his role as father. Social Service has been helpful in allowing him to make decisions about caring for his family while in the hospital. It would have been much simpler to have worked with the wife and for her to do all this herself than to bring him in on the decisions about family problems. However, involvement in decision making for his family helped to maintain his feeling of importance.

The other interrelated area is his sexual function. This man's sexual function is normal and extremely important to him.

Doctor: Could you tell us anything about his social background?

Student: He is married, has three children and has supported them as a garage mechanic. He was born in Virginia, went through the eighth grade, became interested in cars, and taught himself to be a garage mechanic. He has wandered between his family in West Virginia and his wife's family in Baltimore during his married life. For one year prior to admission, he and his family lived with his wife's mother in Baltimore.

Social Worker: I think this case illustrates what a Department of Social Service can do in a hospital. We have attempted to preserve this man's role as husband and father and at the same time have attempted to give him a helping hand with important decisions for his family. He is only 25 years old himself and his wife is 22. There are three small children. This man represents the problem of Appalachia brought to Baltimore.

On the one hand, he is self-taught, has developed his own skills, and has been able to support his family with what he has taught himself. He has a very strong will and this, with his motivation, has carried him through much of the present situation.

On the other hand, both he and his family are ignorant about the resources of the community which might be of help to them and do not know how to go after what they need. He has been in a kind of slump because he is a boy from the country and really doesn't know what to do in the city. When he first became ill, his family separated. They went to relatives, but this was a very unsatisfactory solution since the wife and children didn't like where they were and were very crowded. The Baltimore County Welfare Board picked the family up, but the patient lost contact with his wife for awhile and became very anxious about the family's welfare. He very nearly signed out of the hospital in an attempt to go and find them himself. This, of course, was not a realistic solution to his problem and the Social Service Department was brought into the picture at this time, was able to locate the family and to place it in a situation which was acceptable to the wife, children and husband.

The patient was allowed to go home on weekends to play with his children and to reassure himself that they were getting along well and that he was the father and husband in the family.

Comment

There are sudden catastrophic disruptions in the psychosocial life of a patient suffering a spinal cord injury. The final adjustment of the patient to his disability will depend on the severity of the injury, the past pattern of life, and how he accepts the new roles imposed on him. The final outcome of the patient with a spinal cord injury, assuming good medical care is given, basically depends on the patient himself. The doctor can serve only as advisor and supporter.

This can be better understood by considering the roles that the patient played at different stages in the course of the disease.

1. *Pre-morbid Roles:* The patient was, in a number of ways, a typical product of Appalachia. He was poorly educated and fiercely independent. He had educated himself as an automobile mechanic and had started a family to which he was extremely loyal. His wife's parents lived in Baltimore; his own in West Virginia. Employment opportunities were greater in a large city, but his roots were in West Virginia. He saw himself as undisputed family decision maker, a successful self-made man and provider for his family.

2. *Early Hospital Course:* He played the passive role of patient during the early course of his disease, accepting without question the technical decisions made by the physicians.

3. *Recovery:* As he progressed beyond the acute stage, demands were placed on him for an active part in his rehabilitation program. He became depressed at his slow recovery and began to think that he was not going to make it. Fortunately he suffered few of the major complications of severe spinal cord injuries and began to recover muscle function. He then reasserted his role as decision maker for the family, and with the help of the Social Service Department, was actually helped to play this role.

4. *Post-hospital Roles:* Although inspired for a brief period to take advantage of vocational training opportunities, he did not follow through. His present role in life appears to be much the same prior to hospitalization.

Summary

Successful rehabilitation of a patient with a spinal cord injury requires meticulous attention to the psychosocial dimension as the patient's role changes from that of a passive patient to that of a participant in his re-entry into the community.

SKILL SURGICAL, INC.

S K I L L

SKILL

SUPPLIES & EQUIPMENT
for
PHYSICIANS–SURGEONS
HOSPITALS

5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

MAKE ANY DAY
"Special"
with
BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

F.T.D.

Geo. RADEBAUGH
& Sons

120 Burke Ave. Towson, Maryland 21204
Phone VAlley 5-4300

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number, the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.

3 Ways
to express yourself:
Professionally



Continental
MARK III



Lincoln Continental
MERCURY
Marquis





LET US ASSIST YOU IN YOUR CHOICE OF CARS
AND WHETHER TO LEASE OR OWN.

King Size courtesy, service, savings, plus

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

FREE GIFT for taking a test drive. Come in and inspect our beautiful new facilities.

MONARCH

COUGAR • MERCURY • MONTEGO • CONTINENTAL

5525 BALTIMORE NATIONAL PIKE

Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • Open 9-10 • Sat. 9-9 • CLOSED SUNDAY

Advertisers in This Issue

Abbey Rents 14
A & F Nurses Registry 42
Aids for Hearing, Inc. 100
Arch Laboratories 40
Arundel Federal Savings & Loan Assoc. 28
Baltimore Federal Savings & Loan Assoc. 88
Baltimore Nurses Exchange, Alice Weber 35
Baltimore Oxygen Supply Co., Inc. 42
Belvedere Hotel 42
Bolton Hill Dinner Theatre 28
Brentwood Inn 38
Bristol Laboratories 58
Broadview Restaurant 111
Bryman School 40
Burroughs-Wellcome & Co. 83
Camp, Charis, Kellogg Corset Shop 6
Campbell Soup Company 55
Capital Savings & Loan Assoc. 94
Oscar Caplan & Sons 8
Central Dodge 7
Chesapeake Farm, Inc. 12
Club Venus 111
Cobb-Woods Services 48
Cork 'n Bottle Restaurant 111
Danny's Formal Wear 35
Doctor's Supply Co. 90
Dulaney Towson Nursing & Conv. Home 31
Eastern Research Laboratories, Inc. .....Cover 3
Eleven East Chase St. Corporation 28
Embassy Dairy 14
The Evangelical Press 28
Fedder's Medical Services, Inc. 8
Field's Pharmacy 6
Forty West Volkswagen 31
Franklin Uniform Co. 26
Geigy Pharmaceuticals 25, 86-87, 98-99
The Griffin Agency 32
Hanna Rug Company 82
The Hecht Co. Northwood Rooftop Restaurant .. 111
Highland Hospital 38
Hoechst Pharmaceutical Co. 112
House in the Pines Nursing Homes 41
Huntingdon Research Center .....Cover 2
Hynson, Westcott & Dunning, Inc. 1
Jobst Service Center 27
Koch Associates 17
Lederle Laboratories 2, 14, 22-23, 39
Eli Lilly & Co. 4
Maria's 300 Restaurant 111
Maryland Hospital Services 34
Maryland Volkswagen 104
McNeil Laboratories, Inc. 43
Mead Johnson Laboratories 36-37
Merck Sharp & Dohme 18-20
Metropolitan Washington Blood Banks, Inc. 40
Miller Brothers Restaurant 111
Milton Inn 111
F. O. Mitchell & Bro., Inc. 42
Monarch Lincoln Mercury 118
The Robert Morris Inn 104
Murray-Baumgartner Surg. Instr. Co., Inc. 11
National Drug Company 29-30, 102
Ocean City Convention Hall 90
Palmer House Restaurant 111
Parke, Davis & Co. 16, 46
Chas. Pfizer & Co., Inc., Pfizer Laboratories Division, Terramycin 44-45
Pielke Landscape Services 42
Wm. P. Poythress & Co., Inc. 21
T. Rowe Price Growth Stock Fund, Inc. 14
Professional Systems & Services 11
Geo. Radebaugh & Sons 116
Read's Drug Stores 38
Resinol Chemical Co. 106
Katherine Robb Nursing Home 42
A. H. Robins Co. 15, 40, 80-81
Roche Laboratories .....84-85, Cover 4
Savon Car Rental 17
Manuel Schwartz Hearing Rehab. 48
G. D. Searle & Co. 56-57
Security Business Services, Inc. 33
Security House, Inc. 92
Security Savings & Loan 104
Skill Surgical, Inc. 116
Special Diet Shop 94
State-Sun Federal Savings & Loan Assoc. 100
Sterling Lighting Co. 42
Strasenburgh Laboratories 24
Swartz Cadillac 109
Mano Swartz—Furs 8
Tijuana Tacos 111
Tio Pepe Restaurant 31
Tower Ford 100
Towson Telephone Secretaries 90
Towson Valley Motors 40
D. Stuart Webb Advertising Services, Inc. 42
Westview Lounge & Supper Club 111
Helaine White, Realtor 39
White Rice Inn 111
Wyeth Laboratories 95-96
Zimmermann's Shoes 8

Classified Advertising

POSITIONS AVAILABLE

GP PARTNERSHIP—Percentage of salary. Retiring in 2-3 years. Two-man office. Not doing hospital work, but open staff hospitals available. Good country. Congenial people. Professional and personal data requested. Send reply to: Box #9, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

BOARD CERTIFIED OB-GYN MAN—With established practice in Northeastern Baltimore desires association with another Board-Certified Ob-Gyn practicing in the same area. Write: Box #19, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

LOCUM TENENS DESIRED—Good salary. Practice of IM. Fully equipped office. Call: 437-1655, 233-8434 (Balto.) anytime.

SERVICE OFFERED

MEDICAL ABSTRACTING—From Microfilm. Research, technical writing, no typing. Call: (301) 433-7965, Mrs. Manley.

FOR RENT

THREE-ROOM SUITE—Widow of GP has furnished office in home. Private, 1st floor, front and side entrances. Consists of waiting room, consultation and treatment rooms. Air-conditioned. Equipment included, if desired. Call: 465-3340 (Ellicott City).

BRAND-NEW OFFICE—Waiting room, 2 treatment rooms, consultation room, large X-ray room, darkroom, powder room. 5900 Loch Raven Blvd. Corner of Gleneagle. Separate entrance. Fully a/c, gas heat. Suitable for any kind of practice. Proximity to Good Samaritan Hospital. Rent negotiable. Call: 323-5999 (Balto.) after 5 PM.

FOR SALE

EQUIPMENT—From GP's office: Examining table, sterilizers, small refrigerator, infrared lamp, desk, various chairs, tables and cabinets, upright blood pressure machine, scales, nose and throat machine, various surgical instruments. Call: 656-0051 (Bethesda).

USE CHRISTMAS SEALS



FIGHT EMPHYSEMA
TUBERCULOSIS AND
AIR POLLUTION



after surgery...

To restore tissue depletion of Vitamin B Complex and ascorbic acid induced by the physiological stress of surgery, illness or injury—Increases the recuperative power of convalescence.

beta massive capsules

B COMPLEX WITH VITAMIN C



Thiamine HCl	B_1	10 mg.
Riboflavin	B_2	10 mg.
Pyridoxine HCl	B_6	5 mg.
Cyanocobalamin	B_{12}	4 mcg.
Ascorbic Acid	C	150 mg.
Calcium Pantothenate		20 mg.
Niacinamide		50 mg.

EASTERN RESEARCH LABORATORIES, INC.

302 S. CENTRAL AVE. · BALTIMORE, MARYLAND 21202



from the discord of anxiety...



to emotional harmony

with the aid of antianxiety

Librium®
(chlordiazepoxide HCl)
5-mg, 10-mg and 25-mg capsules

In an age of swift change and challenge, susceptible individuals may experience varying degrees of excessive anxiety. The resulting emotional stress may precipitate significant functional disorders or complicate existing organic disease. In properly individualized maintenance dosage, Librium (chlordiazepoxide HCl) quickly helps relieve anxiety and apprehension, provides useful adjunctive therapy in psychophysiologic disorders—yet seldom impairs mental acuity or ability to function. Librium has demonstrated a wide margin of safety in short- and long-term therapy.

Also available:

Libritabs®
(chlordiazepoxide)

ROCHE
Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcoho and other CNS depressants. As with all CNS-acting drugs, caution patien against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed again its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit t smallest effective dosage (initially 10 mg or less per day) to preclude ato or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiat drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Emp usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measure necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increase and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

WA 791
ING
ROOM

MARYLAND

STATE MEDICAL JOURNAL

VOLUME 18 NUMBER 12
DECEMBER 1969

RECEIVED
JAN 1 3 1970
National Library of Medicine



NATIONAL LIBRARY OF MED
9600 ROCKVILLE PIKE
BETHESDA MD 20014

the right attitude:

The right attitude has earned us an enviable reputation in Baltimore's wide spectrum of health care establishments. We feel that our approach to the problems of the elderly, chronically ill, and convalescent patient makes us different.

Our *people* are not only doing a job but also giving of themselves beyond the call of duty to provide our guests with more than the average amount of service expected.

If the right attitude is what you're looking for . . . concerning a day & night vigil by professional nurses . . . individually programmed meals under the control of our staff dietician — physical, occupational, recreational therapy designed to reach a goal in the patient's care and well-being . . . a pleasant home-away-from-home atmosphere . . . Edgewood Nursing Home should be your first preference.

WATCH FOR OUR GRAND OPENING:

By the first of the year — our completely new 100 bed facility will be finished — we are Baltimore's most centrally located nursing home. Minutes from Towson. Roland Park, Homeland and all of Northern Baltimore's hospitals.

EDGEWOOD
NURSING & CONVALESCENT HOME
6000 Bellona Avenue, 323-4223

Lutrexin®

HW&D BRAND OF LUTUTRIN

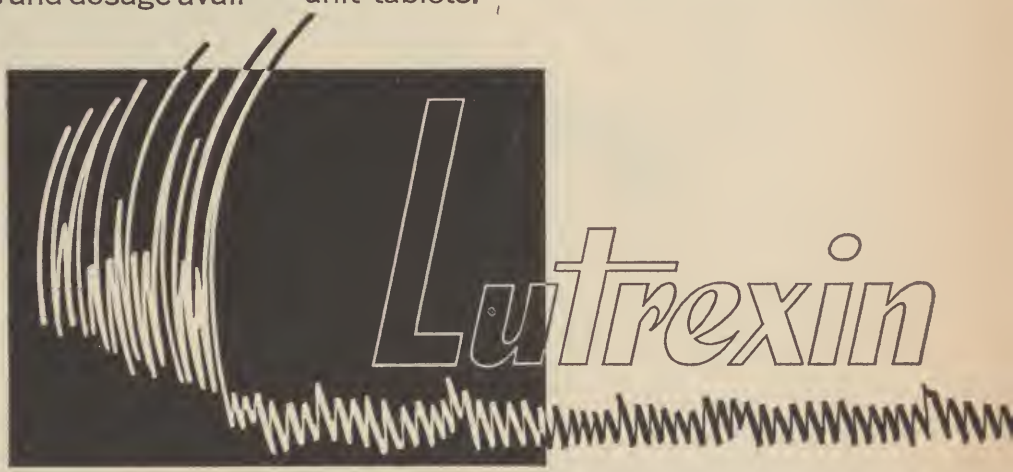
3000 UNIT TABLETS

I THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND SELECTED CASES OF REMATURE LABOR AND 2ND AND 3RD TRIMESTER THREATENED ABORTION

LUTREXIN, the non-steroid "uterine laxing factor" has been found to be useful y many clinicians in controlling abnormal terine activity.

Literature on indications and dosage avail- ble on request.

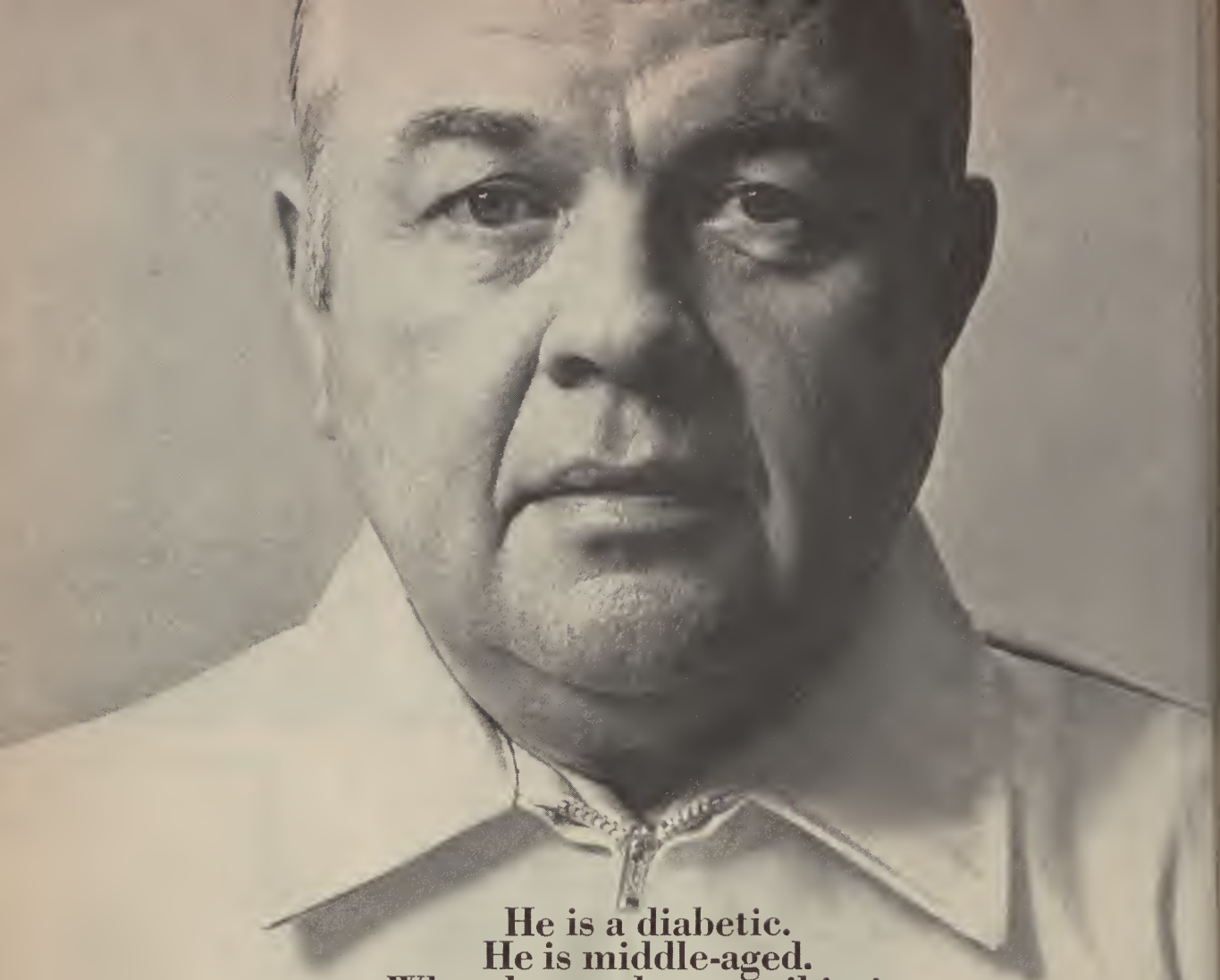
- No side effects have been reported, even when massive doses (25 tablets per day) were administered.
- Supplied in bottles of twenty-five 3,000 unit tablets.



(In vivo measurement of Lutrexin on contracting uterine muscle of the guinea pig.)

HYNSON, WESTCOTT & DUNNING, INC. BALTIMORE, MARYLAND 21201

(LTR23)



He is a diabetic.
He is middle-aged.
When he needs an antibiotic he may be a candidate for

DECLOSTATIN® 300

Demethylchlortetracycline HCl 300 mg and Nystatin 500,000 units CAPSULE-SHAPED TABLETS Lederle

b.i.d.

To guard susceptible patients against intestinal monilial overgrowth during broad-spectrum therapy—the protection of nystatin is combined with demethylchlortetracycline in DECLOSTATIN.

For your susceptible candidates, prescribe DECLOSTATIN —the broad-spectrum therapy that prevents monilial overgrowth.

Effectiveness: Because its antibacterial component is DECLOMYCIN Demethylchlortetracycline, DECLOSTATIN should be equally or more effective therapeutically than other tetracyclines in infections caused by tetracycline-sensitive organisms. The antifungal component, Nystatin, protects against superinfection by antibiotic-resistant fungal overgrowth (particularly monilia) in the intestinal tract.

Contraindication: History of hypersensitivity to demethylchlortetracycline or nystatin.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur stant observation is essential. If new infections appear, appro measures should be taken. In infants, increased intracranial pr with bulging fontanels has been observed. All signs and symptom disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—anorexia, nausea, vomiting, rhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—macul ular and erythematous rashes; a rare case of exfoliative dermatit been reported. Photosensitivity; onycholysis and discoloration nails (rare). Kidney—rise in BUN, apparently dose related. Tra increase in urinary output, sometimes accompanied by thirst (Hypersensitivity reactions—urticaria, angioneurotic edema, anaphy Teeth—dental staining (yellow-brown) in children of mothers give drug during the latter half of pregnancy, and in children given the during the neonatal period, infancy and early childhood. Enamel plasia has been seen in a few children. If adverse reaction or idi crasy occurs, discontinue medication and institute appropriate the Demethylchlortetracycline may form a stable calcium complex ir bone-forming tissue with no serious harmful effects reported thu in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Shoul given 1 hour before or 2 hours after meals, since absorption is imp by the concomitant administration of high calcium content drugs, f and some dairy products. Treatment of streptococcal infections sh continue for 10 days, even though symptoms have subsided.

LEDERLE LABORATORIES

A Division of American Cyanamid Company, Pearl River, New York

Maryland State Medical Journal

VOLUME 18 DECEMBER 1969 NUMBER 12

CONTENTS:

Editorial—Senate Bill 404: A Working Solution to the State's Health Problems, John Sargeant 68

Electrodes for Cardiac Monitoring in the Coronary Care Unit: Description of the Disposable Daisy Electrode, John J. Curry, MD 69

"Cardiac monitoring experience in the Holy Cross Hospital Coronary Care Unit, over a three-year period, is reviewed in respect to the various types of monitoring electrodes employed."

Clinical Uses of Central Venous Pressure, Neil A. Robinson, MD ... 73

"Central venous pressure monitoring (CVP) has become a routine procedure on the wards of most hospitals. Its simplicity and reliability recommend its use in a variety of clinical situations."

Sickle Cell Disease in Pregnancy—A Report on Exchange Transfusions, Norman Levin, MD, Desideria Tabanao-Mahusay, MD 75

"Sickle cell disease is a most serious hemoglobinopathy, complicating pregnancy and causing alarming rates of fetal wastage and maternal mortality. The purpose of this report is to present two recent cases of sickle cell anemia in pregnancy. Both patients were treated with lifesaving transfusions in the obstetrical department of a small community hospital."

Phlebography in Leg Complaints, Salvatore J. DeMarco, III, MD ... 78

"The first phlebograms were performed in man by Berberich and Hirsch in 1923, using Strontium bromide as the contrast material. In 1931, Sgalitzer, Kolbert and Demel described a more acceptable technique. Classic monographs on phlebography of the lower extremities were produced by Bauer and Hellsten in 1940, concerning their study of the effects of heparin therapy in thrombophlebitis. Accepted enthusiastically at first, the technique was soon abandoned due to difficulty with the radiologic technique, contrast material, injection sites, and equipment.

The Mercy Hospital series of 100 phlebograms, begun in 1964 and continued through March 1968, is an attempt to find a more logical approach to the treatment of varicose veins than those that have been reported in the literature."

The Nutritional Status of C/Y Center Children, Alexander J. Schaffer, MD 83

"In February of 1968 the Baltimore City Health Department was asked to participate in a nutritional survey of all children in the Comprehensive Care Clinics across the country. This was to be a cross-sectional study of all the infants and children who appeared for any reason at each center during the months of March and April of 1968. It presented us with a good opportunity to study our own population in Baltimore."

DEPARTMENTS:

Library Page—New Accessions 35

Your Medical Faculty at Work, John Sargeant 87

Maryland State Department of Mental Hygiene—Diagnostic Treatment Trends 89

Baltimore City Health Department 91

Alcoholism—Guidelines for Admission of Alcohol-Dependent Patients to General Hospitals 95

Tuberculosis—Toward Control of Viral Infections of Man 101

Heart Page—The Electrocardiogram in Clinical Alterations of Potassium Homeostasis, Part 1, Ralph Weber, MD 103

Rehabilitation Notes—The Effect of Urinary Diversion on Urinary Tract Disease in Patients with Spinal Cord Injury, Francis J. Borges, MD; Alan Z. Steinberg, student, and Paulo P. Mendonca, MD 113

EDITORIAL and BUSINESS OFFICE: 1211 Cathedral Street, Baltimore, Maryland 21201. 539-0872 (Area Code 301).

©Copyright 1969 by the Medical and Chirurgical Faculty of the State of Maryland.

Maryland. Second Class postage paid at Baltimore, Md. Accepted at the special rate authorized. Published monthly. Subscription $5; Single Copy 75¢.

The views expressed in this publication are those of the authors and do not necessarily reflect the opinions of the Medical and Chirurgical Faculty of the State of Maryland.

EDITOR
C. Thomas Flotte, MD

MANAGING EDITOR
Judy Sowell

EXECUTIVE SECRETARY
John Sargeant

EDITORIAL BOARD
Leon W. Berube, MD
Moses Paulson, MD
Wilber R. Ellis, Jr., MD
E. T. Lisansky, MD
Edward C. H. Schmidt, MD
Edward S. Klohr, Jr., MD

DIRECTOR OF ADVERTISING
Sally Ladin Ogden

Best wishes for a Happy Holiday Season from the Journal staff.

Doctors Take Note 5

Annual Meeting Hotel Reservation 7

Executive Secretary's Newsletter 9

Orient Tour 13

Arts and Hobby Exhibit 19

Annual Meeting News 27

MEDIC 30

Woman's Auxiliary 33

Component Society News 39

Board of Medical Examiners 45

The Month in Washington 51

Medical News 54

Semiannual Meeting Highlights and Minutes 56

Statement of Controlled Circulation 88

Information for Authors 127

Classified Advertising 133

Advertising Index 134


Each 5 cc. contain erythromycin estolate equivalent to 250 mg. erythromycin base.
When mixed as directed, each 5 cc. will contain erythromycin estolate equivalent to 125 mg. erythromycin base.
When mixed as directed, each cc. will contain erythromycin estolate equivalent to 100 mg. erythromycin base.
Each 5 cc. contain erythromycin estolate equivalent to 125 mg. erythromycin base.
Each tablet contains erythromycin estolate equivalent to 125 mg. erythromycin base.
The many forms of Ilosone®
Erythromycin Estolate
Lilly
Additional information available upon request.
Eli Lilly and Company
Indianapolis, Indiana 46206
Each Pulvule® contains erythromycin estolate equivalent to 125 mg. erythromycin base.
Each Pulvule contains erythromycin estolate equivalent to 250 mg. erythromycin base.
900761

Doctors take note...

JANUARY 2-4, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Medicine and Law: University of Southern California Institute of Psychiatry and Law, Los Angeles, California. Director: Seymour Pollack, MD. For information and registration, contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

JANUARY 2-6, 1970
UNIVERSITY OF MIAMI SCHOOL OF MEDICINE

Postgraduate Course—Function and Dysfunction of the Gastrointestinal Tract: The Americana Hotel, Bal Harbour, Florida. Director: Martin H. Kalser, MD, Professor of Medicine and Physiology, University of Miami School of Medicine; Co-director: Arvey I. Rogers, MD, Assistant Professor of Medicine, University of Miami School of Medicine, Chief of Gastroenterology Section, Miami Veterans Administration Hospital. For registration and information, write: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

JANUARY 5-22, 1970
DEPARTMENT OF POSTGRADUATE MEDICINE/ALBANY MEDICAL COLLEGE

Eleventh Medical Seminar Cruise: From New York. Faculty of Albany Medical College will present a comprehensive shipboard postgraduate program, covering subjects in medicine, surgery, pediatrics, obstetrics, and gynecology. Write: Department of Postgraduate Medicine, Albany Medical College, Albany, New York 12208.

JANUARY 6, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Urodynamics as Related to Bactiuria and Genitourinary Infections: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201. Speaker: John D. Young, MD.

JANUARY 8, 15, 22, 29, 1970
MARYLAND DIVISION OF THE AMERICAN CANCER SOCIETY/ REGIONAL MEDICAL PROGRAM OF MARYLAND

Cancer Symposium: North Charles General Hospital, North Charles at 28th St., Baltimore, Md. 21218. The symposium will consist of 13 subjects and speakers. Registration (no fee) will be required. Contact: William Schuman, MD, Director of Medical Education and Postgraduate Institute, North Charles General Hospital, Baltimore, Md. 21218.

JANUARY 9-18, 1970
U. S. DIVISION OF THE INTERNATIONAL FERTILITY ASSOCIATION

North American Conference on Fertility and Sterility: Dorado Hilton Hotel, Dorado, Puerto Rico. The scientific program will cover many important aspects of the topic. For information, contact: Maxwell Roland, MD, Coordinating Chairman, The International Fertility Association, 109-23 71st Road, Forrest Hills, New York 11375.

JANUARY 13, 1970
PHI DELTA EPSILON FRATERNITY

Twenty-fifth Annual Lecture: 11:30 AM, Gordon Wilson Hall, University of Maryland Hospital, Baltimore, Md. Speaker: Dorothy Horstmann, MD, professor of epidemiology and pediatrics, Yale University School of Medicine. Subject: Rubella Vaccine—Problems and Progress. Contact: Ronald Goldner, MD, University of Maryland Hospital, Baltimore, Md. 21201.

JANUARY 15-16, 1970
HEART ASSOCIATION OF MARYLAND

Meeting. Speaker: Richard Gorlin, MD, Peter Bent Brigham Hospital, Boston. Contact: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

JANUARY 20, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Obstructive Disease and Urinary Diversions: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201. Speaker: Earl P. Galleher, MD.

JANUARY 21, 1970
MARYLAND KIDNEY FOUNDATION

Seminar—The Relation of Renal Lymphatics to Function and Disease: 5 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201. Speaker: John J. Murphy, MD, Professor of Urology, University of Pennsylvania School of Medicine.

JANUARY 26-29, 1970
AMERICAN COLLEGE OF PHYSICIANS

Postgraduate Course—Practical Approach to Selected Clinical Problems: Ochsner Medical Foundation, New Orleans, La. Director: C. Thorpe Ray, MD, FACP. For further information, contact: Edward C. Rosenow, Jr., MD, FACP, Executive Director, American College of Physicians, 4200 Pine Street, Philadelphia, Pa. 19104.

JANUARY 27, 1970
NEW YORK HEART ASSOCIATION

Conference—Glomerulonephritis: The Waldorf-Astoria Hotel, Park Avenue and 50th Street, New York, New York. Advance registration is required. Write: New York Heart Association, Inc., 2 East 64th St., New York, New York 10021.

FEBRUARY 2-4, 1970
AMERICAN HEART ASSOCIATION

Three Days of Cardiology—Modern Cardiac Physical Diagnosis: University of Cincinnati Medical Center, Cincinnati, Ohio. For further information, write: Heart Association of Maryland, 415 North Charles Street, Baltimore, Md. 21201.

FEBRUARY 3, 1970
UNIVERSITY OF MARYLAND HOSPITAL

Conference—Tissue Typing for Transplantation: 4 PM, Room 1-704, Psychiatric Institute, University of Maryland Hospital, Redwood and Greene Sts., Baltimore, Md. 21201. Speaker: Robert M. Ollodart, MD.

MAKE YOUR HOTEL ROOM RESERVATIONS NOW

for the

ANNUAL MEETING OF THE MEDICAL AND CHIRURGICAL FACULTY

APRIL 1, 2, 3, 1970

A block of rooms has been set aside at the BELVEDERE HOTEL, Baltimore, for those attending this meeting. Because of many activities in the city, rooms will be at a premium.

The rates are $19.00 for a double or twin bedded room for two persons; single occupancy rate is $15.00; and suites are $25, $30, and $40.00.

FOR YOUR HOTEL RESERVATION DETACH AND MAIL THIS SLIP DIRECTLY TO:

Mrs. Jacqueline Amati
BELVEDERE HOTEL
Charles & Chase Sts., Balto., Md. 21202

Name .....

Address ..... City ..... State .....

Please reserve ..... rooms Approximate rate ..... No. of persons.....

Date of arrival ..... Date of departure .....

Attending Annual Meeting of the Medical and Chirurgical Faculty.
All requests subject to confirmation.

We recommend **CAMP**



SACRO-ILIAC SUPPORTS

Scientific block and tackle lacings cause the durable Camp material to firmly encircle the bony pelvis, in conservative treatment of sacro-iliac conditions. This basic Camp model also provides upper adjustment to balance the support or to ease spasm and pain, depending on the needs of the wearer. Effective for relief of effects of disease and moderate low back injury.

DONALD O. FEDDER, ORTHOTIST

Rents and Sells
Hospital Equipment

Horizon House
1101 N. Calvert St.
685-3848
Baltimore, Md. 21202

Dundalk Office
201 Wise Ave.
284-0700
Dundalk, Md. 21222

First Aid To The Worried



In both of our stores we relieve you of all the shopping tension.

Make your jewelry selections in a pleasant atmosphere, with salespeople who are understanding and who make your Christmas shopping really enjoyable.

If you can't come in—call us, we will do your shopping for you.

Oscar CAPLAN *and Sons*

231 N. Howard St., Baltimore (MU 5-8800)
York Rd. & Investment Pl., Towson (VA 3-5995)
Tidewater Inn, Easton, Md. (TA 2-1553)

Specializing in the fitting of shoes for proper foot function and comfort

ACCURATE PRESCRIPTION WORK

ZIMMERMANN'S

COMFORTABLE SHOES

OUR ONLY ADDRESS LOCATED
227 W. Saratoga St.
Baltimore, Md. 21201

STORE HOURS

Monday, Tuesday, Wednesday, Friday and Saturday . . . 9:30 A.M. to 5:15 P.M.
Thursday . . . 9:30 A.M. to 8:30 P.M.



NATURAL MINK

(various shades)

for her heart's desire

$595.00

Exclusive Maryland Representative of

Oleg Cassini

WORLD-FAMOUS FURS

Maryland's oldest and largest furrier

225 N. HOWARD ST.
BALTIMORE, MD. 21201

Mano Swartz

executive secretary's newsletter

December, 1969

CAUTION ON NARCOTICS

The Bureau of Narcotics and Dangerous Drugs, of the U.S. Department of Justice, has brought to the Faculty's attention the Federal law stating that Class A Narcotics prescriptions may not be telephoned to a pharmacist, except in dire emergencies.

While this may create hardships for some patients, they should recognize that such requests place the physician in jeopardy for violation of the Federal law.

PLASTIC TONGUE DEPRESSORS

A recent Congressional inquiry into a statement circulated by a midwestern hospital supply company revealed the necessity of verifying statements made by companies and individuals.

The supply company distributed a circular stating that wooden tongue depressors had been declared unsafe and unfit for human use by the U.S. Food and Drug Administration.

One institution disposed of its entire supply of wooden tongue depressors and purchased the higher cost plastic ones for replacement.

The hospital supply company is no longer in business.

AMERICAN MEDICAL ASSOCIATION HOUSE MEETS

The Clinical Meeting of the Americal Medical Association House of Delegates met on November 30 of this year. Items under discussion included the controversial report of the Committee on Planning and Development. Because of this report, the House of Delegates established a special Reference Committee to hear comments and remarks on the recommendations contained in the report. Included are:

1. AMA adoption of the World Health Organization definition of Health;

2. Data on the adequacy of health services and the manner in which they are being provided throughout the country should be obtained by the AMA and its components;

AMERICAN MEDICAL ASSOCICATION HOUSE MEETS (cont'd)

3. That the AMA, in conjunction with other heal agencies, continue to explore and develop expedients to overcome health manpower shortgages;

4. That the AMA and its components become mor active in medical economics;

5. That medical representatives to local Blue Pl be currently active in local and national socit affairs and be familiar with society policies.

OTHER NEWS OF INTEREST

At a recent meeting attended by local state society executives it was learned that the National Health Program envisioned by Walter Reuther and being actively promoted through this new "alliance", is not being readily accepted by many of the groups involved in such an "alliance".

Interestingly, the majority of these representatives are opposed to "more government control" as they are disenchanted with the operations of Medicaid and Medicare.

Perhaps it is now being recognized that what can be given by the Government with one hand can be taken away with the other.

ADDITIONAL WARNING TO PHYSICIANS

Physicians throughout Maryland are being deluged with "bills" for listing in the U.S. MEDICAL DIRECTO

Individuals are cautioned about sending in $82 per yea for the cost of such a listing. This is similar to the listings mailed to physicians from California and this group has no connection whatsoever with any official organization.

Physicians are also cautioned that purchase of such a listing would constitute advertising under the Medica Practice Act of Maryland.

John Sargeant
Executive Secretary

BUSINESSWISE

DOCTOR

PROBLEMS WILL ARISE

IN

INDIVIDUAL PRACTICE
PARTNERSHIP
CORPORATION

OR

DIRECT BILLINGS
AND
COMPUTER STATEMENTS

◆

OUR EXPERIENCED SUPERVISION
AND "KNOW HOW"
ARE AT YOUR ELBOW

◆

DIAL 752-5920

Professional Management Co.

914 Aurora Federal Building
Baltimore, Md. 21201

◆

NOT A CURE ALL—BUT
THE BEST AIDE KNOWN

WE RENT AND SELL





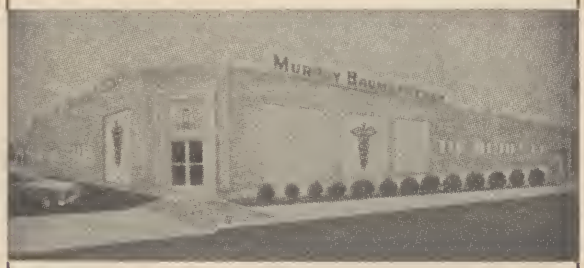
Hospital and Convalescent Equipment

Wide selection of everything needed for patient care in the hospital or at home.

Manual Vari-Hite Hospital Beds
Hydraulic Lifters
Automatic Electric Stair-Glides
Wheel Chairs
Diathermy Machines
Infra-Red Heat Lamps
Ultra-Violet Sun Lamps
Invalid Walkers
Traction Apparatus

MEDICARE FORMS

We have the necessary Medicare forms, and will assist your patients in processing the required information concerning items purchased or rented from us.



Murray-Baumgartner

SURGICAL INSTRUMENT CO., INC.

2501 Gwynns Falls Parkway at Warwick Ave.

Phone: 669-9300 Baltimore, Md. 21216



very interesting!

Baltimore Federal's savings certificates are a very attractive investment, indeed. They earn interest at our current rate (paid by check at regular quarterly interest periods), then earn a bonus at maturity. You can invest from $1,000 to $11,000 in multiples of $1,000 for either six months or a year and earn a total rate of 5% per annum, guaranteed. From $12,000 up, you can invest for either period and earn a guaranteed 5¼% per annum.

Select the savings plan that best suits your needs, not forgetting our flexible, popular, and convenient passbook account. Of course, your money is insured by the Federal Savings and Loan Insurance Corporation.

Open or add to your account by the tenth and you'll earn our undivided interest for the entire month!

BALTIMORE FEDERAL
Savings & Loan Association

Downtown at Fayette and St. Paul Streets

Eastpoint Shopping Center

Reisterstown Road Plaza

Towson at 7 Alleghany Avenue

Carney at 9609 Harford Road

Yorktowne Plaza Shopping Center

Columbia, Teachers Building

Westminster at 6 E. Main Street

MED-CHI TOUR

The Medical and Chirurgical Faculty is sponsoring another exciting tour in the near future:

ORIENTAL CARNIVAL—May 1 to May 17, 1970

A fabulous deluxe tour leaving from Friendship Airport. This is an all-inclusive tour with six fun-filled days and nights in Tokyo, seven glorious days and nights in Hong Kong, three enchanting days in Honolulu. An opportunity is provided to visit the fabulous 1970 Japan World Exposition in Osaka via the famous "Bullet" train (140 m.p.h.). Included are sightseeing tours, a get-together cocktail party, dinners in restaurants of your choice, breakfasts, and many other attractions.

Make your reservations NOW: For information and reservations contact Mrs. Beverly Wolins, Travel Guide Agency, 416 North Charles Street, Baltimore 21201 (301-727-0680) or Mrs. Genevieve Ritchie, the Faculty office, 1211 Cathedral Street, Baltimore 21201 (301-539-0872).

Extra Dollars

for you – with Chesapeake's

EXTRA ¼% DIVIDEND

anticipated for the quarterly dividend period ending Sept. 30.

next dividend period
Oct. 1 to Dec. 31

Chesapeake Federal

SAVINGS & LOAN ASSOCIATION

2240 EASTERN AVE. Corner PATTERSON PARK

ORLEANS 5-6602



Traditional Japanese Cuisine

SUKIYAKI TEMPURA
TERIYAKI SUSHI

. . . and others

COCKTAILS AND MIXED DRINKS

SAKE (RICE WINE)

JAPANESE BEER— ASAHI AND KIRIN

11 A.M.—11 P.M.
CLOSED MONDAY

SAKURA PALACE

7926 Georgia Ave., Silver Spring, Md. 20900

JU 7-7070

T. ROWE PRICE GROWTH STOCK FUND, INC.

BALTIMORE, MARYLAND

A stock portfolio carefully selected for possible growth of principal and income.

NO SALES CHARGE
NO REDEMPTION CHARGE

Offered and Redeemed at New Asset Value

Mail coupon below for a copy of the prospectus.

T. Rowe Price
Growth Stock Fund, Inc.
Dept. I, One Charles Center
Baltimore, Maryland 21201

NAME_____

ADDRESS_____

KNOW YOUR ZENITH DEALER . . .

She can open the door to

BETTER HEARING

HERE'S WHY! Few things in life are as vital as good hearing. So when we became a Zenith dealer, we were determined to give our customers the utmost in help!

- Experienced advice based on Zenith factory training.
- The finest, most advanced Zenith hearing aids ever.
- Batteries, accessories, service for all makes of hearing aids.
- Home appointments on request.



Miss Deeds

ZENITH

"Living Sounds" Hearing Aids

AIDS FOR HEARING, INC.

Miss Gladys Deeds
Manager

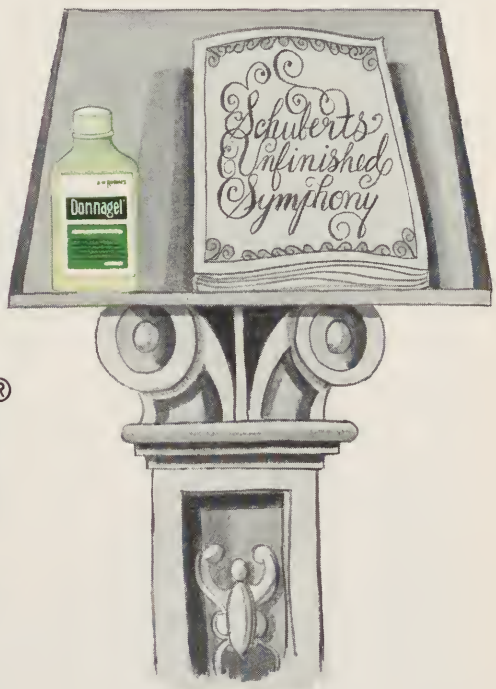
213 West Saratoga St. 727-7011



The concert was just underway,
When to the conductor's dismay
Cramps and diarrhea,
Did so quickly appear,
The maestro no longer could stay.

Because diarrhea with cramping, nausea, and painful straining can
at the most inopportune time, it takes a comprehensive agent to treat the
iarrheal syndrome and help get the patient back on the job. That's why
ny physicians rely on Donnagel, especially during the fall and winter
s when "flu" and viral gastroenteritis usually hit their peak.

Donnagel is much more than just a simple kaolin-pectin combination.
contains the belladonna alkaloids to calm GI hypermotility and help
the distressing discomforts which so often accompany diarrhea. Certainly
s expensive and more convenient than taking two medications. And the
is lower too. Available in the handy 4-oz. plastic bottle at pharmacies
here on your prescription or recommendation.



arrhea and its Discomforts

Donnagel®

uid ounce contains: Kaolin, 6 Gm.; Pectin, 142.8 mg.; Hyoscyamine sulfate,
mg.; Atropine sulfate, 0.0194 mg.; Hyoscine hydrobromide, 0.0065 mg.;
benzoate (preservative), 60 mg.; Alcohol, 3.8%.

ROBINS A. H. Robins Company, 1407 Cummings Drive, Richmond, Va. 23220



PHOTO BY VICTOR



CLEAR THE TRACT!

THERE'S A ROBITUSSIN FOR EVERY COUGHING NEED

All the Robitussins contain gylceryl guaiacolate, an outstanding expectorant agent that greatly increases the output of lower respiratory tract fluid. Increased RTF volume exerts a demulcent effect on the tracheobronchial mucosa, promotes ciliary action, and makes thick, inspissated mucus less viscid and easier to raise.

For coughs of colds and "flu"
ROBITUSSIN®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Alcohol, 3.5%

Non-narcotic for 6-8 hr. cough control
ROBITUSSIN-DM®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Dextromethorphan hydrobromide . . . . 15.0 mg.
Alcohol, 1.4%

For unproductive allergic coughs
ROBITUSSIN A-C®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Pheniramine maleate . . 7.5 mg.
Codeine phosphate . . . 10.0 mg.
(warning: may be habit forming)
Alcohol, 3.5%

Clears sinuses and nasal stuffiness as it relieves cough
ROBITUSSIN-PE®
Each 5 cc. contains:
Glyceryl guaiacolate . . 100.0 mg.
Phenylephrine hydrochloride. . . . . 10.0 mg.
Alcohol, 1.4%

Robitussin-DM in solid form for "coughs on the go"
COUGH CALMERS™
Each Cough Calmer contains:
Glyceryl guaiacolate . . 50.0 mg.
Dextromethorphan hydrobromide . . . . 7.5 mg.

Use this handy guide to pick the right formulation for each coughing need

	Robitussin	Robitussin-DM	Robitussin A-C	Robitussin-PE	Cough Calmers
xpectorant	●	●	●	●	●
emulcent	●	●	●	●	●
ough Suppressant		●	●		●
ntihistamine			●		
ong-Acting (6-8 hours)		●			●
asal, Sinus Decongestant				●	
on-narcotic	●	●		●	●

A·H·ROBINS A. H. Robins Company, Richmond, Va. 23220

Patient Referral Requested

The Immunology Branch of the National Cancer Institute is engaged in a broad program of hematopoietic cell transplantation in an effort to correct bone marrow failure and immune deficiencies. A corollary effort is an evaluation of the anti-tumor effects of immune competent cell transplantation into patients with a malignancy. Thus we are considering for admission to this study a limited number of patients with 1) bone marrow failure or malfunction due to a nonmalignant cause, 2) malignancy, 3) an immune deficiency syndrome. Patients should fulfill the following criteria:

a. the disease process will lead to a fatal outcome within three to six months based on best available clinical judgment;
b. no further effective treatment exists for the disease;
c. the patient has one or more relatives available as potential donors of bone marrow or hematopoietic cells;
d. the patient and family have appropriate motivation for the transplant.

We would appreciate an opportunity to evaluate such patients for inclusion in the program. Evaluation of the patient would involve a visit to the outpatient department at the Clinical Center and the obtaining of blood from the patient and his relatives for histocompatibility testing which will be done in the Immunology Branch laboratories. If the patient is hospitalized and too ill to come to the Clinical Center, one of our staff will visit the hospital and arrange to get the requisite blood samples. Patients who qualify for hematopoietic cell transplantation will be admitted to the National Institutes of Health Clinical Center.

If you know of any such patients or if such patients come to your attention in the future, you may call Dr. G. N. Rogentine at AC 301, 496-2454 or Dr. John L. Fahey at AC 301, 496-5461.

You ARE CORDIALLY INVITED TO INSPECT
THE ALL NEW PRODUCTS FROM FORD FOR 1970 AT

TOWER FORD

BALTIMORE'S LARGEST FORD DEALERSHIP CONVENIENTLY LOCATED
JUST ONE MILE EAST OF JOHNS HOPKINS MEDICAL CENTER
COMPLETELY EQUIPPED SERVICE and PARTS CENTER FEATURING OUR
ELECTRONIC DIAGNOSTIC AUTO ANALYZER
THAT PERFORMS OVER 100 SERVICE CHECKS FOR ONLY $9.95
CHOICE SELECTION OF NEW and ONE-OWNER 1969 MODELS
AT TREMENDOUS SAVINGS

LONG TERM LEASING – DAILY & WEEKLY RENTALS



TOWER Ford

3700 E. Monument St.
675-5515 (Just East of Edison Hwy.)

New and Used Car Depts. Open Daily and Saturday 9 to 9 — Service Depts. Daily 7 to 6. Closed Sat.

Annual Meeting of the Medical and Chirurgical Faculty

APRIL 1, 2, 3, 1970

The Alcazar, Baltimore

An Arts and Hobby Exhibit will be held during the 172nd Annual Meeting of the Medical and Chirurgical Faculty. Physicians, their wives and families are asked to help make this exhibit an outstanding one with many interests on display. Anything made by the exhibitor is eligible. Entries will be accepted until all exhibit space is allotted. Please have exhibits framed or mounted.

Entries should be delivered to The Alcazar, Cathedral and Madison Streets, Baltimore, between 9:00 AM and 4:30 PM on Tuesday, March 31. They must be removed on Friday, April 3, between 1:30 and 4:30 PM. The Faculty cannot carry insurance on your exhibit, but utmost care will be taken of it. There will be a watchman on duty when the meeting is not in session. Probably the exhibitors' personal policies will cover the exhibit.

Certificates will be awarded to the prize-winning exhibits. The names of exhibitors received by February 1, 1970, will be listed in the printed Annual Meeting program. However, all entries should be submitted as early as possible.

Committee for Arts and Hobby Exhibits:

Mrs. Charles H. Williams, *Chairman*
Mrs. George H. Yeager, *Chairman, Judging*
Mrs. Kurt Lederer
Mrs. Marvin I. Mones

APPLICATION FOR ARTS AND HOBBY EXHIBIT

Fill in and mail to: Chairman, Arts and Hobby Exhibit
Medical and Chirurgical Faculty
1211 Cathedral Street, Baltimore 21201

1. Title of exhibit: .....

.....

2. Amount of space required—depth, width, and height: .....

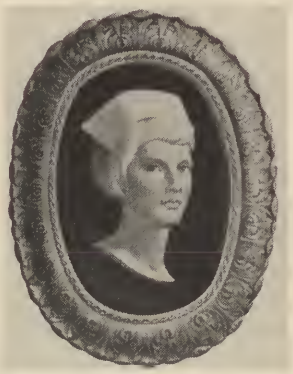
3. Electrical or other requirements: .....

4. Name of exhibitor: .....
Please print

5. Address of exhibitor: .....

6. Telephone number of exhibitor: .....

SKILLED MEDICAL ASSISTANTS
and
MEDICAL RECEPTIONISTS
are now available from



THE BRYMAN SCHOOL

. . . a part of the nation's largest network of schools specializing in preparing women for auxiliary positions in medicine.

Telephone 821-5222

32 WEST ROAD TOWSON, MARYLAND 21204

DOCTORS SUPPLY COMPANY

All Surgical and Medical Supplies and Biologicals

FAST SERVICE
FAIR PRICES

Fill all needs from one source

DIAL MED-ICAL
633-4225

20 Dundalk Ave.,
Dundalk, Md. 21222

ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE ONE STOP SYSTEMS PEOPLE

RAYTHEON SERVICE CO.

the service co. you call for demonstration of:

VIDEO TAPE RECORDERS
TV MONITORS
TV CAMERAS
TV ACCESSORIES

SALES and SERVICE
761-4300

RAYTHEON SERVICE CO.
103 ROESLER RD., GLEN BURNIE, MD.

A COMPLETE ORTHOPEDIC and CORRECTIVE DEPARTMENT

To Fill Your Doctor's Prescription

The following types are carried in stock:



- Thomas Heel Oxfords and High Tops
- Straight Last
- Pronators
- Supinators
- Pre-Walking Reverse and Straight Last
- Dennis Brown Splints Rented

BRIDGEFORTH'S JUNIOR BOOTERY

Edwards
THE SHOES FOR CHILDREN

4426 Park Heights Ave.
Baltimore, Maryland 21215
664-4914



"All Interns are Alike"

It stands to reason. They all go through the same training; they all have to pass the same tests; they all have to measure up to the same standards; they all are underpaid, too. Therefore, all interns are alike.

That's utter nonsense, of course. But it's no more nonsensical than what some people say about aspirin. Namely: since all aspirin is at least supposed to come up to certain required standards, then all aspirin tablets must be alike.

Bayer's standards are far more demanding. In fact, there are at least *nine specific differences* involving purity, potency and speed of tablet disintegration. These Bayer® standards result in significant product benefits including gentleness to the stomach, and product stability that enables Bayer tablets to *stay* strong and gentle until they are taken.

So next time you hear someone say that all aspirin tablets are alike, you can say, with confidence, that it just isn't so.

You might also say that all interns aren't alike, either.



Mild ulcerative colitis may be triggered here...



In mild ulcerative colitis, a number of factors can precipitate an attack: for instance, dietary indiscretion, such as eating raw foods, or emotional overreaction, such as that aroused by financial difficulties. No matter what causes the patient's sensitive colon to "act up," he soon suffers from acute discomfort...and often, from anxiety and apprehension as well. Such patients frequently respond well to adjunctive dual-action Librax® therapy.

Librax combines, in a single convenient capsule, the well-known antianxiety effect of Librium® (chlordiazepoxide HCl) and the dependable anticholinergic/antispasmodic effect of Quarzan® (clidinium Br). Therefore, as Librax helps to relieve the patient's excessive anxiety and reduce his overreaction to stress, it also, at the same time, helps to control hypersecretion and hypermotility, thus relieving spasm and abdominal discomfort.

With Librax, the dosage schedule is simple: 1 or 2 capsules, t.i.d. or q.i.d., will in most cases bring the patient significant relief of both the emotional and physical elements that contribute to his psychovisceral disorder.

Before prescribing, please consult complete product information, a summary of which follows.

INDICATIONS: Indicated as adjunctive therapy to control emotional and somatic factors in gastrointestinal disorders.

CONTRAINDICATIONS: Patients with glaucoma; prostatic hypertrophy and benign bladder neck obstruction; known hypersensitivity to chlordiazepoxide HCl and/or clidinium bromide.

WARNINGS: Caution patients about possible combined effects with alcohol and other C depressants. As with all CNS-acting drugs, c tion patients against hazardous occupations quiring complete mental alertness (*e.g.*, operat machinery, driving). Though physical and p chological dependence have rarely been repor on recommended doses, use caution in ministering Librium (chlordiazepoxide hyd chloride) to known addiction-prone individu or those who might increase dosage; withdraw symptoms (including convulsions), followi discontinuation of the drug and similar to th seen with barbiturates, have been reported. U of any drug in pregnancy, lactation, or in wom of childbearing age requires that its potent benefits be weighed against its possible hazar As with all anticholinergic drugs, an inhibiti effect on lactation may occur.

PRECAUTIONS: In elderly and debilitate limit dosage to smallest effective amount to p clude development of ataxia, oversedation confusion (not more than two capsules per d initially; increase gradually as needed and tol

or here.



Though generally not recommended, if ination therapy with other psychotropics ees indicated, carefully consider individual harmacologic effects, particularly in use of po- erating drugs such as MAO inhibitors and hothiazines. Observe usual precautions in rence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimula- ion and acute rage) have been reported in psy- hotic patients. Employ usual precautions in reatment of anxiety states with evidence of im- ending depression; suicidal tendencies may be present and protective measures necessary. Vari- able effects on blood coagulation have been reported very rarely in patients receiving the ug and oral anticoagulants; causal relation- ship has not been established clinically.

ADVERSE REACTIONS: No side effects or manifestations not seen with either compound ave been reported with Librax. When hlordiazepoxide hydrochloride is used alone, drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally with chlordiazepoxide hydrochloride, making periodic blood counts and liver-function tests advisable during protracted therapy. Adverse effects reported with Librax are typical of anticholinergic agents, *i.e.*, dryness of mouth, blurring of vision, urinary hesitancy and constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diet.

two good reasons for prescribing LIBRAX®

Each capsule contains 5 mg chlordiazepoxide HCl and 2.5 mg clidinium Br.

ROCHE LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



No place for beginners

Terramycin®
(oxytetracycline)

An infection of rapid onset requiring prompt attention. Teenage girl with chills, fever, abdominal pain, backache and nausea. Frequent and urgent urination with burning. On examination—tenderness over kidney. Blood count and urinalysis confirm the diagnosis: acute pyelonephritis. Treatment is initiated with Terramycin. Within a few days of follow-up therapy, the patient is markedly improved. The pretreatment urine culture shows a strain of *E. coli* highly susceptible to Terramycin.

Experience has shown that Terramycin offers special advantages in treating urinary tract infections when strains of causative bacteria are susceptible. Broad-spectrum coverage unaffected by penicillinase. Effective tissue levels to help reach foci of infection in renal parenchyma. High urine levels—excreted by kidney in *active* form.

With Terramycin, you have the assurance that comes with choosing an agent physicians have depended on for over 18 years. In difficult as well as routine cases, when tests reveal susceptible organisms, consider Terramycin. One of the world's most widely used broad-spectrums.

Contraindicated: In individuals hypersensitive to oxytetracycline.

Warnings: Reduce usual oral dosage and consider antibiotic serum level determinations in patients with impaired renal function.

Use of oxytetracycline during the last trimester of pregnancy, neonatal period and early childhood may cause discoloration of developing teeth. This effect occurs mostly during long-term use of the drug, but it has also been observed in usual short-treatment courses.

During treatment with tetracyclines, individuals susceptible to photodynamic reactions should avoid direct sunlight; if such reactions occur, discontinue therapy.

Note: With oxytetracycline, phototoxicity is unknown and photoallergy very rare.

Precautions: Use of broad-spectrum antibiotics occasionally may result in overgrowth of nonsusceptible organisms. Where such infections occur, discontinue oxytetracycline and institute specific therapy. Increased intracranial pressure in infants is a possibility. Symptoms disappear upon discontinuation of therapy.

Adverse Reactions: Nausea, diarrhea, glossitis, stomatitis, proctitis, vaginitis and dermatitis, as well as reactions of an allergic nature, may occur but are rare.

Supply:* Terramycin Capsules: oxytetracycline HCl, 250 mg. and 125 mg. Terramycin Syrup: calcium oxytetracycline, 125 mg. per 5 cc. Terramycin Pediatric Drops: calcium oxytetracycline, 100 mg. per cc.

*All potencies listed are in terms of the standard, oxytetracycline.

More detailed professional information available on request.



Terramycin®
(oxytetracycline)

Pfizer LABORATORIES DIVISION
New York, N.Y. 10017



the price maker's
prices on the new '70 Dodges
beat all other prices
without Arithmetricks

CENTRAL DODGE
1111 Cathedral Street
Phone 685-3797
OPEN DAILY 9 TO 9
SATURDAYS 9 TO 6

P.D.Q. SERVICE ESPECIALLY FOR DOCTORS *Professional, Dependable, Quick Auto Repairs. Our service department has instructions to give precedence to doctors in immediate, accurate electronic diagnosis and prompt, expert therapy on any make car to avoid unnecessary delay in your valuable service to the community.*

172nd ANNUAL MEETING

Medical and Chirurgical Faculty of the State of Maryland

APRIL 1, 2, 3, 1970

The scientific sessions of the 1970 Annual Meeting will be held at the Alcazar in Baltimore. Scheduled to present papers are

Daniel M. Gordon, MD
Associate Professor of Ophthalmology
Cornell University Medical College
New York

George James, MD, Dean
Mount Sinai School of Medicine
New York

Roy W. Menninger, MD, President
The Menninger Foundation
Topeka, Kansas

William H. Moretz, MD, Chairman
Department of Surgery
Medical College of Georgia

John Rock, MD
Clinical Professor Emeritus of Gynecology
Harvard Medical School
Director, Rock Reproductive Clinic, Inc.
Cambridge, Massachusetts

Felix Wroblewski, MD
Associate Professor of Clinical Medicine
Cornell University Medical College
New York

Medical Grand Rounds will be presented by A. McGehee Harvey, MD, and staff members of the Department of Medicine of The Johns Hopkins University. Surgical Grand Rounds will be presented by Robert W. Buxton, MD, and staff members of the Department of Surgery of the University of Maryland.

Other activities scheduled are

Annual Round-Table Luncheon, at the Belvedere Hotel, will include luncheon meetings of the alumni associations of several medical schools, and informal scientific discussions

Hospitality Night—this proved so very popular at the 1969 Meeting, that it will be repeated in 1970 at the Belvedere Hotel—vocal and instrumental entertainment will be provided

Annual Presidential Reception and Banquet—at the Blue Crest North, well known for its delectable cuisine, hors d'oeuvres, and cocktails—in a delightful atmosphere with professional entertainment, and dancing for everyone to the music of Rivers Chambers' Orchestra

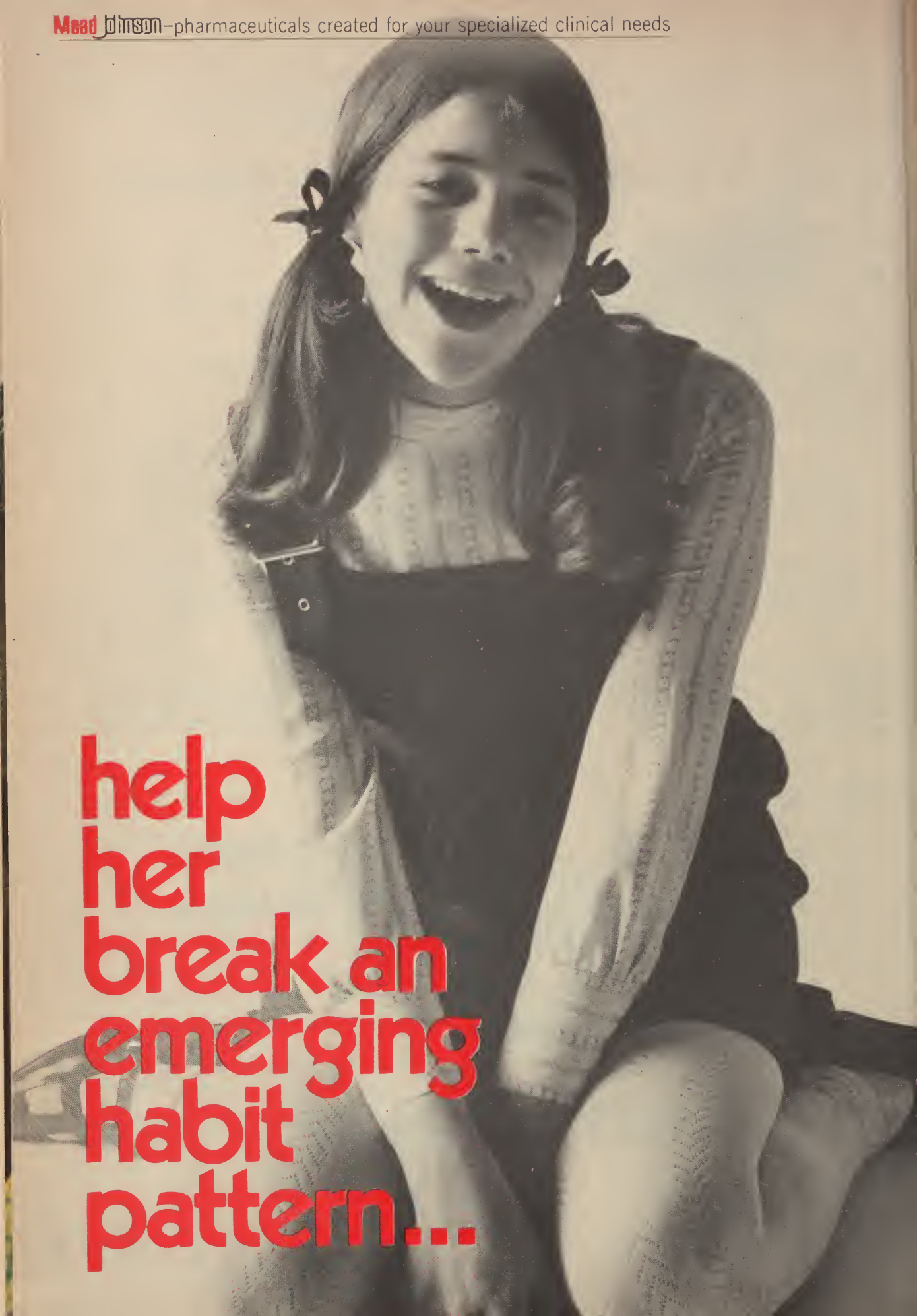
Arts and Hobby Exhibit—at the Alcazar—a chance for you to put your unusual talents on display (see page 19 for the application form)

Health Evaluation Tests—at the Alcazar—an easy way to get your semiannual checkup

Scientific and technical exhibits will be on display each day of Annual Meeting at the Alcazar—the exhibits constitute a symposium on therapeutic progress

Committee on Program and Arrangements
DeWitt E. DeLawter, MD, *Chairman*

Mead Johnson–pharmaceuticals created for your specialized clinical needs



help her break an emerging habit pattern...

GYNOREST®
(DYDROGESTERONE)

helps break the emerging habit pattern of nonorganic primary dysmenorrhea.

Early relief of primary dysmenorrhea in the adolescent may lessen its tendency to become a habit pattern "which is very difficult to interrupt."* Dydrogesterone proves to be "...an extremely satisfactory drug...the most conservative type of progestational agent..."* for relief of severe and incapacitating dysmenorrhea in adolescents.

Gynorest provides these distinct advantages

normal cycles usually undisturbed... no inhibition of ovulation...occasional breakthrough bleeding can usually be controlled by dosage adjustment

mild, infrequent side effects... withdrawal is seldom required

freedom from estrogenic and androgenic effects... progestational in action

Mead Johnson
LABORATORIES

ontraindications No serious untoward reactions to Gynorest have been reported and there are no known contraindications to its use. here have been no adverse effects observed clinically on the hepatic, renal, or hemopoietic systems. **Precautions** Before hormonal treatment considered in patients with excessive or abnormal uterine bleeding, the cause of such bleeding should be determined on an individual asis. Appropriate procedures should be used to determine whether an organic lesion or systemic disease is the cause of the bleeding. lthough never reported for Gynorest, it should be borne in mind that other progestogens have been observed to cause fluid retention hich on occasion may result in exacerbated attacks of epilepsy, migraine or asthma. **Adverse Reactions** Gynorest appears to be nontoxic. ild gastrointestinal complaints such as nausea, diarrhea, or constipation have rarely been reported, but have not necessitated withdrawal the drug. There have been no endocrinologic side effects such as masculinization of a female fetus, virilization of a female patient, or y corticosteroid activity reported from the use of Gynorest. Breakthrough bleeding can usually be controlled by increasing the dosage by giving the drug in smaller doses at more frequent intervals to maintain a more constant blood level. **Dosage and Administration** Complete details are included in the package insert. Additional information may be obtained from Mead Johnson Laboratories. **Supplied** 10 mg. hite Scored Tablets, bottles of 100, or 5 mg. White Scored Tablets, bottles of 50.

ones, Georgeanna S.: Maryland Med. J. 16:45, 1967.

© 1969 MEAD JOHNSON & COMPANY • EVANSVILLE, INDIANA 47721 65969

the professionals, incorporated

Now physicians, attorneys, dentists, accountants, and other professionals can gain important benefits from corporation planning.
Write or call for the facts from Executive Consulting Services about profit sharing, pension planning, and additional new benefits now available, since passage of Maryland Senate Bill 149

Clip and mail to
ecs Executive Consulting Services, Inc.
Vermont Federal Building,
Baltimore, Maryland 21201, Phone PL 2-3866

Name _____

Address _____

City _____ State _____ Zip



MEDIC 1970 SCHEDUE

JANUARY 9, 1970 — 12:30 PM

GIANT CELL ARTERITIS

Philip A. Tumulty, MD
Professor of Medicine
The Johns Hopkins University School of Medicine

Giant cell arteritis proves to be a systemic illness of major significance. The natural history, problems in differential diagnosis, unusual clinical manifestations and treatment will be emphasized.

Sponsor: GREATER BALTIMORE MEDICAL CENTER

Replays:	Monday, January 12, 1970	12:30 PM
	Wednesday, January 14, 1970	9:00 AM
		2:00 PM

JANUARY 16, 1970 — 12:30 PM

GLOMERULONEPHRITIS

C. Robert Cooke, MD
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

Abou D. Pollack, MD
Chief of Pathology
Baltimore City Hospitals
Associate Professor of Pathology
The Johns Hopkins University School of Medicine

Acute glomerulonephritis will be considered from the standpoint of diagnosis and management. Correlation of the symptomatology with the pathological findings in a representative case will be presented.

Sponsor: BALTIMORE CITY HOSPITALS

Replays:	Monday, January 19, 1970	12:30 PM
	Wednesday, January 21, 1970	9:00 AM
		2:00 PM

JANUARY 23, 1970 — 12:30 PM

STERILIZATION, PREP AND ISOLATION TECHNIQUES

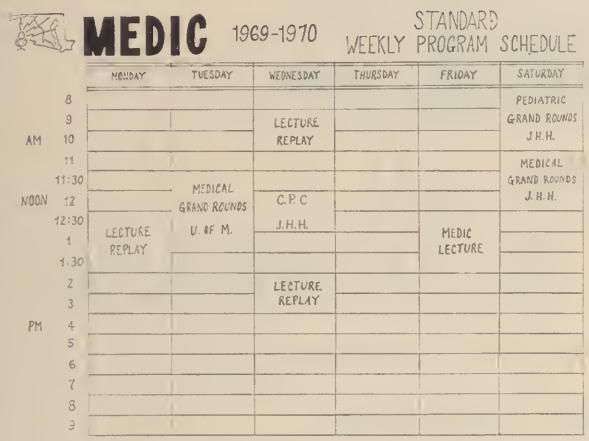
John J. White, MD
Assistant Professor of Pediatric Surgery
The Johns Hopkins University School of Medicine

It is becoming apparent that infections are more frequently due to organisms endogenous to the patient himself than to contamination from his surroundings. Current aseptic methods range from those based on established evidence, through those that lack good evidence but appear rational, to those that seem to be based on ritual. Prepping solutions and techniques, isolation and protection systems and sterilization will be discussed.

Sponsor: FREDERICK MEMORIAL HOSPITAL

Replays:	Monday, January 26, 1970	12:30 PM
	Wednesday, January 28, 1970	9:00 AM
		2:00 PM

POSTGRADUATE PROGRAMS



CONTINUING PROGRAMS

(Heard at participating hospitals only)

TUESDAY MORNINGS — 11:30 AM
MEDICAL GRAND ROUNDS
University of Maryland Hospital

WEDNESDAY MORNINGS — 12 NOON
C. P. C.
The Johns Hopkins Hospital

SATURDAY MORNINGS — 8:00 AM
PEDIATRIC GRAND ROUNDS
The Johns Hopkins Hospital

SATURDAY MORNINGS — 10:00 AM
MEDICAL GRAND ROUNDS
The Johns Hopkins Hospital

SPECIAL INTEREST PROGRAMS

Joint Anesthesia Study Committee of the Baltimore City Medical Society and the City Health Department

Presentation of Cases 7:30 PM

January 27 February 24 March 24
April 28 May 26

Supported in part by a grant from
Merck Sharp and Dohme

(See page 96 for a list of participating hospitals)

REDUCE YOUR TAXES

Many doctors are enjoying significant tax savings through Sheltered Investment Programs made possible by professional incorporation.

Let one of our professional representatives explore the advantages of professional incorporation with you, your attorney, or your accountant.

For an immediate appointment, with no fee or obligation, call, write, or send the following coupon to:

T. C. HORNE & CO., Inc.

201 Maryland Avenue, N.E.

WASHINGTON, D. C. 20002

Phone (202) 547-4377

Gentlemen:

Please schedule an immediate appointment with

☐ me ☐ my attorney ☐ my accountant

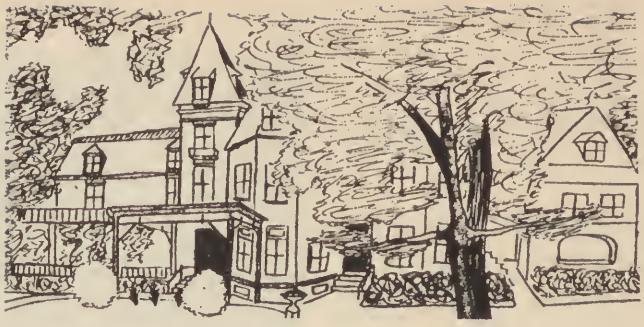
for a discussion of professional incorporation

Name .....

Street .....

City & State .....

Telephone .....



ANNOUNCING THAT

The GUNDRY SANITARIUM

*Established 1900 * * * Continually Growing and Modernizing*

(1) . . . HAS BEEN ACCREDITED FOR 3 YEARS BY THE JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

(2) . . . HAS BEEN CERTIFIED AS A PARTICIPATING HOSPITAL FOR HEALTH INSURANCE UNDER SOCIAL SECURITY (MEDICARE)

The GUNDRY SANITARIUM, a complete psychiatric community, includes a 33-bed Inpatient Hospital for female patients, a Night Hospital for female patients, a Day Hospital for male and female patients, and an Outpatient Department for patients of all ages.

Wouldn't you feel satisfied knowing that your patient is receiving care in a hospital with all these advantages:

- **Treatment is based upon intensive individual and group psychotherapy combined with drug therapy when indicated**
- **All the Doctors are highly trained Psychiatrists**
- **Highly trained Nursing and Medical staff is available 24 hours a day**
- **Environment is warm and homelike.**
- **Protected against fire by approved sprinkler system**
- **Competent medical consultation in all fields is available**
- **Close liaison with the referring physician is maintained**
- **All forms of occupational and recreational activities are offered**
- **Follow-up care in the Day, Night or Outpatient Service**
- **RATES are reasonable; outpatient fees on a sliding scale.**

The GUNDRY SANITARIUM

2 N. WICKHAM ROAD **BALTIMORE, MD. 21229** **Phone 644-9917**

Psychiatric Hospital
licensed by the
State of Maryland

Rachel K. Gundry, M.D.
MEDICAL DIRECTOR

ACCREDITED FOR 3 YEARS BY JOINT COMMISSION ON ACCREDITATION OF HOSPITALS

CERTIFIED AS A PARTICIPATING HOSPITAL FOR HEALTH INSURANCE UNDER SOCIAL SECURITY

MRS. FRANK A. FARAINO, EDITOR

The *Slant* on Mini Workshops

Mini workshops were a new feature of the 1969 Fall Conference of the Woman's Auxiliary to the American Medical Association, which was attended by Mrs. Wallace Sadowsky, president, and Mrs. Raymond Yow, president-elect. The 26th annual conference of state presidents, presidents-elect, national officers and chairmen was held at Chicago's Drake Hotel, October 5-8.

The conference opened Sunday evening with four regional dinners chaired by Mrs. G. Prentiss Lee, Portland, Oregon, first vice president. Our Eastern Region Dinner was presided over by our regional Vice President, Mrs. Herbert J. Ulrich from Snyder, N. Y. This was a get-acquainted and renew-old-friendships meeting plus a bird's eye view of what to expect at the conference.

Mrs. John M. Chenault, president, opened the Monday, October 6 session. Gerald D. Dorman, MD, President of the AMA, delivered the keynote address. Dr. Dorman congratulated the auxiliary on its anti-violence campaign and encouraged everyone to continue the auxiliary involvement with youth. He reminded us of the AMA and auxiliary's main objective—"best health care for all the people."

Headlining the morning program was Howard A. Schneider, MD, Head of the Experimental Medical Ecology Department of AMA's Institute for Biomedical Research. Dr. Schneider referred to the auxiliary as the "Institute's staunchest and greatest support."

Next, A. Brooks Parker, Jr., director of Tennessee Health Careers, offered a dynamic health careers presentation especially designed to reach the "now generation." Mr. Parker talked about the successful health careers campaign being conducted throughout Tennessee and showed a slide presentation called "The Health Teams," which is being used as a part of the recruiting program. His informative talk made us want to get involved in all sorts of career programs right now!

The morning program concluded with discussions by Mrs. Carl Welch, president, and Mrs. G. Edward Kappler, president-elect, of the Woman's Auxiliary to the Student American Medical Association.

Ernest B. Howard, MD, AMA executive vice president, was the guest speaker at the Monday luncheon. Dr. Howard commented on the quantity and quality of health care today. He added that the AMA's major need is to identify itself as a national group with concerns of the nation in health care and "do something about it."

The afternoon session centered around "The Auxiliary at Work in the Community." Eight auxiliary women participated in a skit titled "How to Present a Package Program," which offered some practical applications of the auxiliary's package program on alcoholism. Our own Mrs. Wallace Sadowsky was one of the eight actresses. The program concluded with the film, "A New Look at the Old Sauce," from the Texas Commission on Alcoholism.

The Monday session ended with a dinner sponsored by the AMA Public Affairs Division and The American Medical Political Action Committee. Mrs. Frank Gastineau, secretary-treasurer of AMPAC, introduced the guest speaker, the Hon. Robert Packwood, (R), U.S. Senator from Oregon.

Senator Packwood discussed "You, Too, Can Be a Leader," focusing his presentation on women in politics. He referred to the qualities of leadership which can be learned or taught as purpose, integrity, tolerance, discipline, and imagination. However, he added there is a sixth quality called zeal which cannot be learned or taught. "If you master zeal," Packwood remarked, "you will have all the qualities of good leadership."

The Tuesday session began with mini workshops. The group was divided into five sections according to size of state membership, while five program extension committee chairmen rotated from room to room and presented ideas for implementation on the state level. The workshops held were Community Health, International Health, Mental Health, and Safety-Disaster Preparedness. The Community Health Chairman, Mrs. Linus Hewitt, told of rural as well as urban health needs, pointed out similarities, and showed how health careers recruitment, especially in rural health is so much a part of community health. We were also told that January has been designated blood donor month.

Mrs. Jacob Ripp, our Eastern Regional Director

of International Health, told of the continuing need for books and teaching material, as well as medical supplies and clothing. Different agencies that handle this and ways of shipping were also discussed. We were shown items that are made of leftovers and throw aways. A sleeping mat crocheted from bread wrappers was very unique and seemed very practical.

Mrs. Willard C. Serivner, chairman of Home Centered Health Care, explained the three different areas of home center care: homemaker services, meal service, and volunteer friendly visitors. The three areas require enthusiastic volunteers from all service organizations. The Pennsylvania Auxiliary works with home center care which is funded by assorted agencies of the state. We were given a short description of the agency and its work by our Eastern Regional Director, Mrs. M. A. Bergnes of Norristown, Pa. Mrs. J. J. Levin from Wisconsin told of meal service as it worked in her home town and also said how appreciative shut ins are of the Volunteer Friendly Visitors. She reminded us of a very important hint that we tend to forget, don't become discouraged, these projects are a long process of research, hope and recruitment.

The Mental Health Chairman, Mrs. Jonathan Williams, told us the stress was still on drugs and alcohol. We were advised that panel programs work well on drug abuse and we saw several interesting pamphlets on glue sniffing, LSD, amphetamines, and barbiturates.

Mrs. John Halseth, Safety-Disaster Preparedness Chairman, announced that Highway Safety will be emphasized this year. We were pleased to learn that the changes in state law being stressed concerning an implied consent law has been accomplished in Maryland. If you've renewed your driver's license recently you have discovered that you must sign a statement on the application giving your agreement to obey the implied consent law. We also have compulsory driver education in the high schools, and defensive driving courses are offered throughout the state by the state troopers. If you haven't taken advantage of this course you should—it really might mean the difference between "safe or sorry."

Following the "Table Talk" luncheon program, Donald L. Taylor, executive vice president of the Iowa Medical Society, recounted how "The Auxiliary Works With the Medical Society."

The afternoon concluded with a three-part program on "The Auxiliary Tells Its Story." Mrs. G. Prentiss Lee, membership committee chairman, Mrs. Sherman Arnold, and Mrs. Bernard Campbell discussed the auxiliary's contributions to its members. Mrs. Hartwell Dunn and Mrs. Josiah Fuller told of the auxiliary's work with other organizations while Mrs. J. Paul Sauvageot, communications committee chairman, Mrs. John M. Wagner, editor of *M.D.'s Wife,* and Mrs. Richard A. Sutter, editor of *Direct Line,* discussed the auxiliary's relationship to the public.

The Wednesday meeting began with a tour of AMA headquarters. The remainder of the morning was devoted to a film presentation in the AMA's 9th floor auditorium. Mrs. Paul E. Rauschenbach, chairman of the committee on children and youth, introduced the new film by the National Foundation called "More Than Love."

Rev. Paul B. McCleave, director of the AMA's Department of Medicine and Religion, presented "A Storm, A Strife," the new AMA medicine and religion film. Both of these films are excellent and I hope both can be used in Maryland.

Mrs. John Chenault gave a brief report on the action taken by the executive board at the morning meeting. It was unanimously decided to send a letter of condolence to Art Linkletter on the tragic loss of his daughter and offer him encouragement and support on his announced campaign against drugs.

The board also is recommending that members of WASAMA be asked to work with WAAMA on recruitment programs for health careers.

The meeting adjourned following the showing of the auxiliary's participation in closed circuit TV taped during the AMA annual convention in July, 1969, in which our own Show and Tell was seen.

We left the workshops motivated—now all we have to do is motivate everyone in Maryland.

Mrs. Raymond M. Yow

Normandy Farm

Potomac, Maryland

Open All Year Long
Every Day
Complete Bar Service
Every Day



Your Hosts—James Speros & Sons
Credit Cards Honored
Air-Conditioned

Oliver 2-9421 Poplar 2-3964

LDG
LUCAS DESIGN GROUP



Contract Interior Design Division of Lucas Bros., Inc.
221 East Baltimore St. ■ MU 5-3000



PAUL F. GUERIN, MD, CHAIRMAN
Library and History Committee
ELIZABETH SANFORD
Librarian

library

BEST WISHES
for
HAPPY HOLIDAYS
from
THE MED-CHI
LIBRARY STAFF

NEW ACCESSIONS—BOOKS

(Arranged by author and title)

Alexander, Franz Gabriel.
Fundamentals in psychoanalysis. New York, Norton, 1948.

American Medical Association. Council of Mental Health. Committee on Alcoholism and Drug Dependence.
Drug dependence; a guide for physicians. Chicago, AMA, 1969.

Barbet, Pierre.
A doctor at Calvary; the Passion of Our Lord Jesus Christ as described by a surgeon. New York, P. J. Kenedy, 1953.

Barker, Joseph M.
The unipolar electrocardiogram, a clinical interpretation. New York, Appleton, 1952.

Carlson, Anton Julius.
The machinery of the body. 4th ed. Chicago, U. of Chicago Press, 1953.

Clague, Alice J.
Trends in illegitimacy: United States, 1940-1965. Washington, U.S. Department of Health, Education, and Welfare, Public Health Service, 1968.

Cole, Warren Henry.
First aid, diagnosis and management. 5th ed. New York, Appleton, 1960.

Figge, Frank H.J.
Programmed guide to the study and dissection of the human body. 2nd rev. ed. New York, Hoffner Pub. Co., 1968.

Foulk, William T., ed.
Diseases of the liver. New York, Blakiston Division, McGraw-Hill, 1968.

Gelfand, Michael.
Philosophy and ethics of medicine. Edinburgh, London, E&S Livingstone, 1968.

Interdisciplinary Conference on Neonatal Respiratory Adaptation, Princeton, N.J., 1963.
Neonatal respiratory adaptation; proceedings. Bethesda, Md., U.S. Department of Health, Education, and Welfare, Public Health Service, National Institutes of Health, National Institute of Child Health and Human Development, 1966.

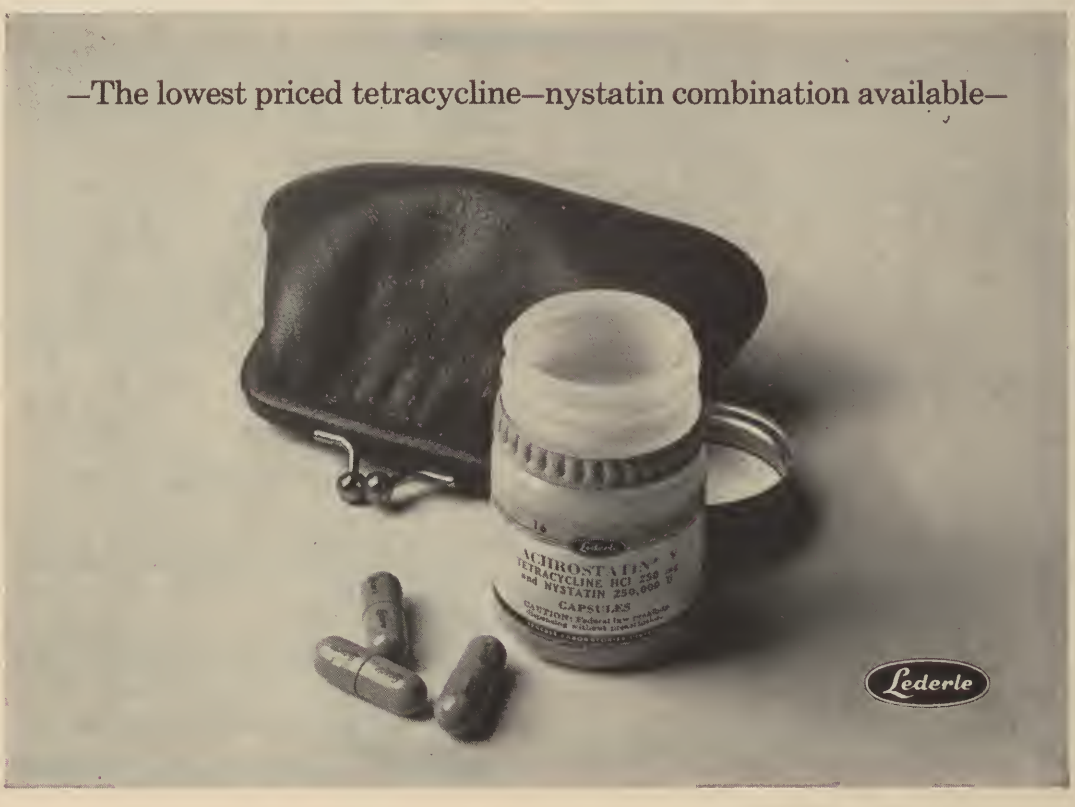
International Symposium on Toxicology of Carbon Disulphide, Prague, 1966.
Toxicology of carbon disulphide; proceedings. Amsterdam/New York, Excerpta Medica Foundation, 1967.

Jaffe, Bernard.
Crucibles; the great chemists, their lives and achievements. New York, Tudor, 1937.

Johnson, John.
Disorders of sexual potency in the male. 1st ed. Oxford, New York, Pergamon Press, 1968.

Kovar, Mary Grace.
Employment during pregnancy; legitimate live births, United States, 1963.
Washington, U.S. Public Health Service, 1968.

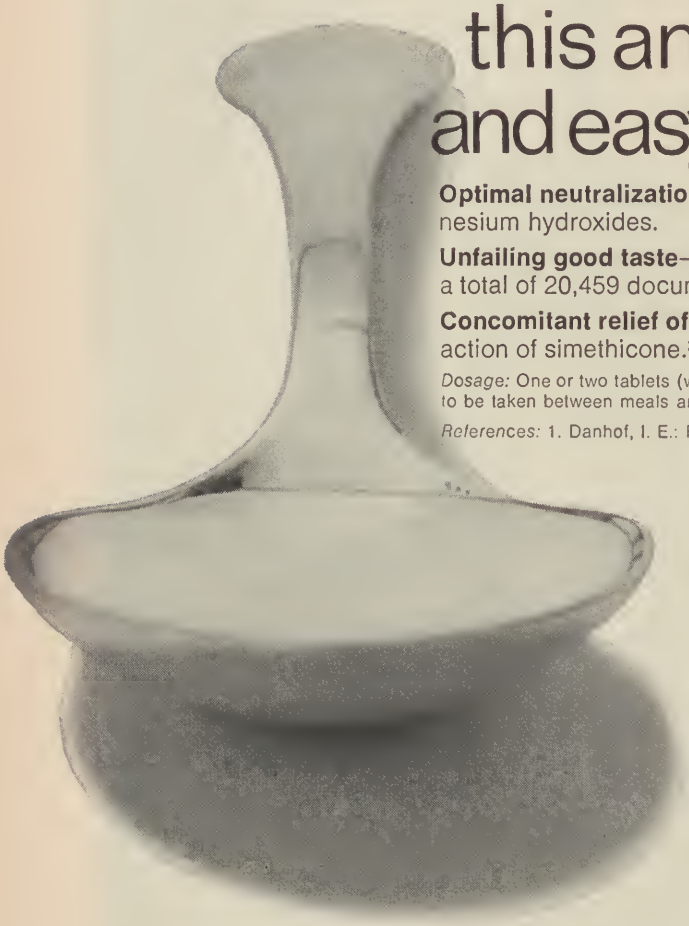
Krantz, John C.
A portrait of medical history and current medical problems. Baltimore, John D. Lucas, 1962.
Lambert, Sylvester Maxwell.
A Yankee doctor in paradise. Boston, Little, Brown, 1941.
Ludwig, Alfred Oscar.
Psychosomatic aspects of gynecological disorders; seven psychoanalytic case studies. Cambridge, Harvard University Press, 1969.
Lusted, Lee B.
Introduction to medical decision making. Springfield, Ill., C.C. Thomas, 1968.
Lutz, Edwin George.
Practical art anatomy. New York, Scribner's, 1918.
Margulies, Harold.
Foreign medical graduates in the United States. Cambridge, Harvard University Press, 1969.
Medical and Chirurgical Faculty of the State of Maryland.
Opportunities for physicians in Maryland. Baltimore, Medical and Chirurgical Faculty of Maryland, n.d.
Medical and Chirurgical Faculty of the State of Maryland. Library.
Dental books and periodicals in the Medical and Chirurgical Library. Baltimore, Maryland State Dental Association, 1965.
Michigan. University. Conference on Aging, 1952.
Housing the aging. Ann Arbor, University of Michigan Press, 1954.
Moorhead, John J.
Harlow Brooks, man and doctor. New York, Harper, 1937.
National Congress on the Socio-Economics of Health Care. 3rd. Chicago, 1969.
Papers. Sponsored by the Council on Medical Science and the Division of Health Service, American Medical Association, March 28-29, Palmer House, Chicago. Chicago, AMA, 1969.
Oursler, William Charles.
Marijuana: the facts, the truth. New York, P. S. Eriksson, 1968.
Perry, Seymour, ed.
Human tumor cell kinetics. Lecture series held at the National Institutes of Health from Nov. 1, 1967 to April 17, 1968. Bethesda, Md., U.S. Public Health Service, 1968.
Symposium on the Physiology and Pathology of Human Reproduction, 2nd, Detroit, 1966.
The ovary; proceedings. Springfield, Ill., Thomas, 1968.
U.S. Bureau of Disease Prevention and Environmental Control.
Programming chronic disease laboratory services. A summary of multiregional seminars. Washington, U.S. Public Health Service, 1967.
U.S. Public Health Service. Health Services and Mental Health Administration.
Community health service; publications catalog. Washington, G.P.O., 1969.
U.S. Public Health Service. National Institute of Health. Division of Regional Health Programs.
News, information, data. May 1967—Bethesda, Md., U.S. Department of Health, Education, and Welfare, 1967, 1968, 1969.
U.S. Social Security Administration.
Disability evaluation under Social Security; a handbook for physicians.
Washington, G.P.O., 1969.
White, Robert Winthrop.
The abnormal personality, a textbook. 2nd ed. New York, Ronald Press Co., 1956.
Wynder, Ernest L., ed.
Toward a less harmful cigarette, a workshop held at the World Conference on Smoking and Health, Sept. 11-13, Bethesda, National Cancer Institute, 1968.




New practice?
Heel thyself.
And the best way to do the heeling is with a Professional Loan from Mercantile-Safe Deposit and Trust Company. The Mercantile Professional Loan is especially designed to help you through the financial rough spots of properly outfitting a modern office.
You can get all the details by calling (823-7400) or by writing: Mercantile-Safe Deposit and Trust Company; Professional Department; 409 Washington Avenue; Baltimore, Maryland 21204.
Let "The Merc" heel you quickly. And keep you heeled with a sensible repayment plan.
MERCANTILE-SAFE DEPOSIT and TRUST COMPANY

the thousandth teaspoonful

Peptic ulcer patients find the thousandth dose of this antacid as effective and easy-to-take as the first!



Optimal neutralization—provided by the combination of aluminum and magnesium hydroxides.

Unfailing good taste—confirmed by 87.5% of 104 patients in one study, after a total of 20,459 documented days on Mylanta Liquid or tablets.[1]

Concomitant relief of G. I. gas distress—provided by the proven antiflatulent action of simethicone.[2]

Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. *93*:467 (Sept.) 1966.

Mylanta®
LIQUID/TABLETS
aluminum and magnesium hydroxides *plus* simethicone

Stuart Division/ATLAS CHEMICAL INDUSTRIES, INC./Pasadena, Calif. 91109

ARTHUR E. COCCO, MD
Journal Representative

Baltimore City Medical Society

Meeting Minutes

Six of the Members of the Board of Directors of the Baltimore City Medical Society met at 1211 Cathedral St., Baltimore, Md., on Tuesday, October 14, 1969 at 4:30 PM for their monthly meeting.

The meeting was called to order by R.C.V. Robinson, MD, president. The minutes of the September 2, 1969 meeting were read and approved by the Board.

The first item on the agenda was a report by Robert B. Goldstein, MD, secretary, informing the Board that the minutes of the Board of Directors meetings of the Baltimore City Medical Society are presently in the process of being bound for preservation.

The next item on the agenda was the discussion of a letter addressed to Dr. Robinson from M. B. Levin, MD. Dr. Levin, in his letter, questions clarification of definitions of a legally constituted voting quorum. Dr. Levin offered several pertinent comments in his letter, pointing to specific deficits he believes are at present in existence. The comments offered by Dr. Levin provoked much discussion by the members of the Board and were finally referred to William Evans, Esq., Parliamentarian of the Baltimore City Medical Society, for further clarification and definition.

Dr. Robinson read a letter from Robert E. Farber, MD, Commissioner of Health, Baltimore City Health Department, announcing the recent availability of a new service through the Baltimore City Health Department. This project, known as the Geriatric Evaluation Service, is funded by a federal grant under Title III of the Older Americans Act, supplemented by a Community Mental Health Services grant from the State Department of Mental Hygiene. The goal of this program is to reduce admissions to state mental hospitals of city residents 65 years and older. This program is designed to provide medical, social, and psychiatric evaluation on elderly persons for whom mental hospital admission is pending and to assist relatives or agents in solving the problem of how best to care for aging, mentally impaired patients. It is hoped that the service can search out and use existing community resources in an attempt to prevent unnecessary hospitalization. Only those persons aged 65 or over, who are residents of Baltimore City, will be accepted. Prompt evaluation in the patient's home or present environment will follow. When a physician is known to be caring for the patient, project staff will be in touch with him before taking any further action. The project staff will appreciate the endorsement and cooperation of the Baltimore City Medical Society in this venture. The project director, Mrs. Mary Guth, will be glad to provide any further information necessary. She may be reached at the project offices located in the Good Samaritan Hospital, 5601 Loch Raven Boulevard, Baltimore, Md. 21212, telephone 323-2200, ext. 279 or 267. The Board of Directors greeted this announcement with enthusiasm and felt it indeed worthwhile and pledge the cooperation of the Society.

The next item on the agenda was a discussion of Medi-Card, Inc. This program is a medical finance service of a post-payment variety. This program is similar to that of Diner's Card, American Express, etc. and is soon to begin operation in the State of Maryland. The program was discussed in detail by the Board of Directors who chose to follow that stand presently assumed by the American Medical Association of neither approving nor disapproving of the Medi-Card concept.

Next, was a report from the Professional Relations Committee, concerning two society members against whom complaints have been filed. These cases were carefully evaluated and disposed of in appropriate manner.

The next item referred to the Board of Directors from the Professional Relations Committee was concerned with the administration of Methadone to narcotic addicts during their period of confinement to the City Jail. The Board of Directors felt that their support should be in agreement with that opinion offered by the governing board and responsible physician in charge of the present city penal program.

The discussion of utilization of extended care facilities, provoked by a letter from the Director of Medical Care Corps Agency of the Mutual of Omaha Corp., urging the Baltimore City Medical Society to sponsor a Utilization Committee for Nursing Homes, took place. After careful consideration, the Board of Directors felt that since this problem was of state-wide involvement, and since all nursing homes are licensed by the State Health Department, that agency should be responsible for utilization review.

The next item considered by the Board of Directors was the election of Harry B. Smith, MD, an active member of the Baltimore City Medical Society since 1944, to the status of Emeritus membership.

A request for support for the Tuberculosis Control Program in Baltimore City, on behalf of its effort to gain continued support of a federal grant was submitted. The Board agreed to continue its endorsement of this program.

Other new business included a discussion of a tentative buffet dinner in association with a future meeting of the Baltimore City Medical Society, the Board agreed that this possibility was worthy of further consideration and subsequent finalization of plans will be pursued.

The meeting was adjourned at 6:30 PM.

A & F Nurses Registry



LICENSED & BONDED
- MALE & FEMALE
- GRADUATE
- UNDERGRADUATE
- PRACTICAL
- COMPANION NURSES

Registered & Licensed

For Private Home Hospitals Institutions

D. S. Anderson, Mgr. Dir.
24 Hour Service

613 E. 32nd St.
613 Homestead St.

BElmont 5-7135
If no answer call: HOpkins 7-6746
Baltimore, Md. 21218

5%
special interest accounts
$3,000 to $25,000

- ☐ Interest calculated on minimum quarterly balances and credited semi-annually (April 1 and October 1).
- ☐ New Accounts opened by the 10th of any month earn interest from the 1st of the month.
- ☐ Deposits received by the 10th of the first month of any quarter earn interest for the full quarter.
- ☐ Deposits or withdrawals in $1000 multiples may be made at any time.
- ☐ Rate on Regular Savings Accounts . . . 4½% per annum.

you ought to use Eutaw

EUTAW SAVINGS BANK

EUTAW AND FAYETTE STS.
AND SIX CONVENIENT BRANCH OFFICES

MEMBER FDIC

Inner Sites...

In Cystitis...Azo Gantanol® focuses analgesic-antibacterial activity where it counts



The mucosa: specific analgesia usually within 30 minutes

Azo (phenazopyridine HCl) effects specific mucosal analgesia, relieving the dysuria, discomfort and burning which are virtually always a part of acute urinary tract infections.

Interstitial fluids: ready diffusion of antibacterial

Gantanol (sulfamethoxazole) is readily diffused into interstitial fluids to provide efficient antibacterial activity at foci of infection. This distribution, plus continuous antibacterial levels in blood and urine, has afforded effectiveness in the majority of infections in which it has been used.

Blood and urine: therapeutic antibacterial levels within 2 hours for up to 12 hours

Gantanol (sulfamethoxazole) produces prompt and prolonged therapeutic levels, in both blood and urine, with convenient *b.i.d.* dosage. Clinical response is usually obtained within 24 to 48 hours. The wide antibacterial spectrum of Gantanol includes *E. coli* and a variety of other susceptible gram-negative and gram-positive pathogens in urinary tract infections.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Urinary tract infections with associated pain or discomfort when due to susceptible organisms; prophylactically in urologic surgery, catheterization and instrumentation.

Contraindicated in sulfonamide-sensitive patients, pregnant females at term, premature infants, newborn infants during the first three months of life, glomerular nephritis, severe hepatitis, uremia and pyelonephritis of pregnancy with gastrointestinal disturbances.

Warnings: Use only after critical appraisal in patients with liver damage, renal damage, urinary obstruction or blood dyscrasias. If toxic or hypersensitivity reactions or blood dyscrasias occur, discontinue therapy. In closely intermittent or prolonged therapy, blood counts and liver and kidney function tests should be performed.

Precautions: Observe usual sulfonamide therapy precautions including maintenance of an adequate fluid intake. Use with caution in patients with histories of allergies and/or asthma. Patients with impaired renal function should be followed closely since renal impairment may cause excessive drug accumulation. Occasional failures may occur due to resistant microorganisms. Not effective in virus and rickettsial infections.

Adverse Reactions: Headache, nausea, vomiting, urticaria, diarrhea, hepatitis, pancreatitis, blood dyscrasias, neuropathy, drug fever, skin rash, Stevens-Johnson syndrome, injection of the conjunctiva and sclera, petechiae, purpura, hematuria or crystalluria may occur, in which case the dosage should be decreased or the drug withdrawn.

ROCHE

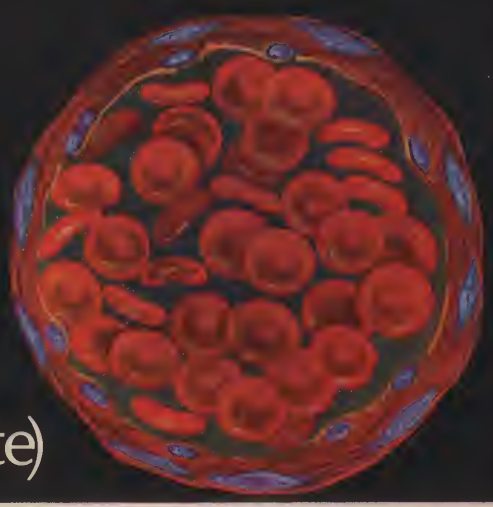
Roche
LABORATORIES

Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Azo Gantanol®

(Each tablet contains 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl.)

Roniacol® Timespan®
(nicotinyl alcohol tartrate)



Because peripheral vasodilatio is needed now... and must often be continued

Roniacol Timespan (nicotinyl alcohol tartrate) can make a significant contribution to effective treatment of peripheral vascular disorders. It is directed specifically toward improvement of peripheral blood flow, relief of ischemic symptoms, and the long-term management of these conditions.

Specific pharmacologic action—Roniacol (nicotinyl alcohol) acts selectively by relaxing smooth muscle of peripheral blood vessels. Onset of action is smooth and gradual, rarely causing severe flushing.

Relative freedom from side effects—Side effects that may occur occasionally with Roniacol seldom require discontinuation of therapy

Prolonged, continuous drug release—Pro- s longed peripheral vasodilation is provided sustained-release Roniacol Timespan (nicc alcohol tartrate) Tablets. Part of the drug b comes available immediately, the remaind continuously over a period of up to 12 hou and dilation of constricted peripheral vess usually maintained. Thus, with a single dos medication, patients can enjoy the benefit increased peripheral blood flow in ischem extremities for up to 12 hours.



nooth peripheral vasodilation from initial osage...extended with inple, well-tolerated, b.i.d. dosage

e rolonged action of Roniacol Timespan c:inyl alcohol tartrate) together with its benefits offer a therapeutically practical ure in the long-term management of ineral vascular disease–advantages cially important for older patients.

ce prescribing, please consult complete uct information, a summary of which lows:

lations: Conditions associated with ient circulation; e.g., peripheral vascular e:e, vascular spasm, varicose ulcers, cbital ulcers, chilblains, Meniere's syn- e and vertigo.

Caution: Roche Laboratories endorses caution in the administration of any therapeutic agent to pregnant patients.

Side Effects: Transient flushing, gastric disturbances, minor skin rashes and allergies may occur in some patients, seldom requiring discontinuation of the drug.

Dosage: 1 or 2 Timespan Tablets—150 mg nicotinyl alcohol in the form of the tartrate salt—bottles of 50 and 500.

ROCHE **Roche** LABORATORIES
Division of Hoffmann - La Roche Inc.
Nutley, New Jersey 07110

Art is a conception of peripheral vasodilation.

A once-popular treatment for back pains was to have the seventh son of a seventh son stand or walk on the patient's back.





The pain of earache was allegedly relie by holding a hot roasted onion to the ear

For headache, a sovereign remedy was to wear a snakeskin round one's head.



A realistic approach to pain relief



'Empirin'®

Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains:
Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

keeps the promise of pain relief

'B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.

BURROUGHS WELLCOME & CO. (U.S.A.) INC.
Tuckahoe, N.Y.

BOARD OF MEDICAL EXAMINERS OF MARYLAND
1211 Cathedral Street
Baltimore, Maryland 21201

Addenda to Directory of Registered Physicians—
Physicians licensed and registered in Maryland from March 1, 1969 through October 16, 1969

A

Aaby, Gene Victor, 42 Orchard Way No., Potomac, Md.
Ackerman, Robert Marshall, 1918 K St., N.W., Wash., D.C. 20006
Adkinson, N. Franklin, Jr., 2010 McElderry St., Baltimore, Md. 21205
Aita, John Fordyce, 8 W. Bend Ct., Baltimore, Md. 21207
Albert, Martin Lawrence, 166 Allen Rd., Rockville Centre, N.Y. 11570
Alig, Howard Marion, 1 Hillbrook Ct., Apt. 303, Timonium, Md. 21093
Allen, John Vincent III, Crownsville St. Hosp., Crownsville, Md. 21032
Allen, Thomas Ernest, Sheppard-Pratt Hosp., Towson, Md. 21204
Alman, Michelle Jessica, 215 W. Seminary Ave., Lutherville, Md. 21093
Alvaran, Simeon B., 4206 V.F.W. Lane, Ellicott City, Md. 21043
Alvarez, Rafael Abelardo, Central St. Hosp., Milledgeville, Ga. 31062
Anderson, Chester Marion, Jr., 225 Manor Cr., Takoma Park, Md. 20012
Andrews, Henry Gibbs, 5041 Green Mtn. Cr. #2, Columbia, Md. 21043
Angeles, Ramon U., Jr., 8600 Chateau Dr., Potomac, Md. 20854
Annis, Frank Lloyd, 1200 N. State St., Los Angeles, Calif. 90033
Anthonisen, Nicholas Rioch, 4531 Everett St., Kensington, Md. 20795
Applefeld, Mark Michael, 4 Breton Hill Rd., Apt. 1-A, Pikesville, Md. 21208
April, Robert Samuel, 3401 Keswick Rd., Baltimore, Md. 21211
Ardis, Mark Burkett, 6016 Avon Dr., Bethesda, Md. 20014
Arroyo, Jose Cleofe, 7134-E Rolling Bend Rd., Baltimore, Md. 21207
Auguste, David Emmanuel, 35 E St., N.W., Washington, D.C. 20001
Ayella, Robert John, 2905 Charles St., Baltimore Apts., Baltimore, Md. 21218

B

Baker, Dole Parker, 2122 Cedar Cr. Dr., Baltimore, Md. 21228
Banwell, John Gordon, Dept. Medicine, Johns Hopkins Hosp., Baltimore, Md. 21205
Barker, Laurel Morgan, 2 St. Elmo Ct., Cockeysville, Md. 21030
Baruch, Jack, 10401 Old Georgetown Rd., Bethesda, Md. 20017
Bashir-Elahi, Abbas, 3308 Sleepy Hollow Rd., Falls Church, Va. 22044
Bath, Patricia Era, 4705 Henry Hudson Pkwy., Riverdale, N.Y. 10471
Battle, Constance Urciolo, 67 Eastland Ave., Rochester, N.Y. 14618
Bauer, Harold Eugene, 711 Linden Ave., Riverton, N.J. 08077
Beaudoin, Donald Evan, 1528 Northwick Rd., Baltimore, Md. 21212
Beebe, Hugh Grenville, 1010 Wagner Rd., Ruxton, Md. 21204
Beller, Robert Francis, 6002 Ryland Dr., Bethesda, Md. 20034
Beltran, Edilberto R., 6139 Leesburg Pike, Falls Church, Va. 22041
Benjamin, Steven Noel, 6110 Breezewood Dr., Apt. 204, Greenbelt, Md. 20770
Bensinger, Richard Edward, 524-A N. Bond St., Baltimore, Md. 21205
Bentolila, Luis Felipe, 7507 Riverdale Rd., New Carrollton, Md. 20784
Berens, Stephen Clark, 10731 Bucknell Dr., Wheaton, Md. 20902
Berryman, John David, 71 Shipwright St., Annapolis, Md.
Beyer, Emanuel Charles, 1111 Clagett Dr., Rockville, Md. 20851
Bhushan, Chhabi, Johns Hopkins Hosp., Baltimore, Md. 21205
Billig, Nathan, 9260 Edmonston Rd., Greenbelt, Md. 20770
Black, Henry Richard, 2300 Georgian Woods Pl., Wheaton, Md. 20902
Blalock, Tully Talbot, Jr., 2948 Habersham Way, N.W., Atlanta, Ga. 30305
Blumberg, Morton Barry, 2808 Marnat Rd., Baltimore, Md. 21209
Bolen, James Lee, 550 N. Broadway, Apt. 507, Baltimore, Md. 21205
Boytar, Alexander Arpad, 325 E. Main St., Newark, Delaware 19711
Braitman, Barbara Sue, Box 114, Rt. 1, Lutherville, Md. 21093
Brigio, Frank Daniel, P.O. Box 259, Bridgeton, N.J.
Broaddus, Robert Eugene, 409 Barkes Ct., R. D. #3, Aberdeen, Md. 21001
Brown, James Moses, 4545 Wheeler Rd., S.E., #506, Wash., D.C. 20021
Brown, Norcliffe Everston, 6013 Eastern Ave., N.E. #7, Wash., D.C. 20011
Brown, Thomas Larry, 4510 Aspen Hill Rd., Rockville, Md. 20853
Brull, Stanley, 3 Cobblestone Ct., Baltimore, Md. 21215
Brysk, Marcel, 730 Appleberry Dr., San Rafael, Calif. 94903
Bucher, Bruce Myron, 5952 E. Pratt St., Baltimore, Md. 21224
Buchignani, John Shea, Jr., 1265 Union Ave., Memphis, Tenn. 38104
Byler, Robert E., Smithburg, P.O., Md. 21783

C

Calia, Frank Michael, 5063 Blacksmith Dr., Columbia, Md. 21043
Capote, Jorge Adalberto, 3915 Warner Ave., Apt. B-2, Hyattsville, Md. 20784
Carlson, David Roland, 5526 Callander Dr., Springfield, Va. 22151
Carnathan, Robert Joseph, 774 College Pkwy., Rockville, Md. 20850
Carr, Jack Neerken, 3907 Woodlawn Rd., Chevy Chase, Md. 20015
Carr, Noel Austen Victor, Harlem Hosp. Center, New York City, N.Y. 10037
Carson, Gordon Cubbedge III, 9308 Cherry Hill Rd., College Pk., Md. 20740
Carter, Michael Frank, 610 N. Bond St., Baltimore, Md. 21205
Chisholm, Reginald Constantine, 1818 Metzerott Rd., Adelphi, Md. 20783
Christopher, Nicholas Louis, 18 Clybourne Ct., Towson, Md. 21204
Cilliani, Gaston F., 6104 E. Pratt St., Baltimore, Md. 21224
Clark, Joseph Martin, 12308 Village Sq. Terr., #402, Rockville, Md. 20852
Coates, Charlotte Elaine, The Sheppard-Pratt Hosp., Towson, Md. 21204
Cochran, Robert Carter, 1601 Gruenther Ave., Rockville, Md. 20851
Cohan, Vaughn D., 7200 S.W. 83rd St. Plaza, #E118, Miami, Fla. 33143
Cohn, Cal K., 3716 "S" St., N.W., Wash., D.C. 20007
Cole, William Stephenson, 14600 Crossway Rd., Rockville, Md.
Collis, Peter Buckley, OSC Box 237, Walter Reed Gen. Hosp., Wash., D.C. 20012
Colvin, Oliver Michael, 196 Stanmore Rd., Baltimore, Md. 21212
Conant, Richard Henry, 6521 Greentree Rd., Bethesda, Md. 20034
Condon, James Robert Kilmartin, 1913 McElderry St., Baltimore, Md. 21205
Conley, Edward Harold, 1539 9th Ave., Apt. 4, San Francisco, Calif. 94122
Connolly, John Robert, 13410 Dowlais Dr., Rockville, Md.
Connors, Richard Charles, 5501 Halpine Pl., #101, Rockville, Md. 20851
Cook, David Gershon, 261 Congressional Lane, Rockville, Md. 20852
Cook, James Ralph, 12403 Village Sq. Terr., Rockville, Md. 20852
Corder, Michael Paul, 4510 Harling Lane, Bethesda, Md. 20014
Cordes, Charles Kenneth, 11832 Charles Rd., Wheaton, Md. 20906
Cottrell, John Charles, Box 409, V.A. Hosp., Coatesville, Pa.
Cowell, Henry Richard, P.O. Box 269, Wilmington, Delaware 19899
Cristofori, Fred Carpi, 5400 Grosvenor Lane, Bethesda, Md. 20014
Crumpacker, Clyde S. II, 4536 N. Chelsea Lane, Bethesda, Md. 20014
Curtis, Vernon Louis, 7600 Carroll, Takoma Park, Md.
Custer, Leroy Evan, 1615 Thetford Rd., Baltimore, Md. 21204
Cutler, Leonard Dean, 5202 Crossfield Ct., Rockville, Md. 20852
Cutlip, Basil Duncan, Jr., 17604 Prince Edward Dr., Olney, Md. 20832

D

D'Albora, James Bartholomew, 11600 Hitching Post Lane, Rockville, Md. 20852
Dalton, William Edward, 9 Middleton Ct., Baltimore, Md. 21212
Daniels, Roswell George, U.S.A.E.H.A., Edgewood Arsenal, Md. 21010
Davidov, Howard Allen, 3701 Menlo Dr., Baltimore, Md. 21215
Dearworth, James Robert, 11 Knollwood Rd., Glen Farms, Md. Via Newark, Delaware 19711
Deegan, Michael John, #3 Dalecrest Ct., Timonium, Md. 21093
Dela Cruz, Natividad Fernandez, 201 8th St., N.E., Apt. 41, Wash., D.C. 20002
De Lisio, John, Mt. Wilson St. Hosp., Mt. Wilson, Md. 21112
Dennis, James B., 104 Mt. Vernon St., Smyrna, Delaware 19977
Deuel, Ruthmary Knebel, 5523 Grosvenor Lane, Bethesda, Md. 20014
Diaz, Fernando G., 897 Arnett Dr., Newport News, Va. 23602
Diaz, Haroldo Rosendo, 1500 S.W. 13th Ave., Miami, Fla. 33145
Dim, Bomen Hitzi, 11559 Links Dr., Reston, Va. 22070
Di Maio, Vincent J. M., 24 Wooded Way, Pikesville, Md. 21208
Di Simone, Robert Nicholas, 1600 Winford Rd., Baltimore, Md. 21212
Drachman, Daniel Bruce, Dept. of Neurology, Johns Hopkins Hosp., Baltimore, Md. 21205
Duick, Daniel Stephen, 13320 Turkey Branch Pkwy., Rockville, Md. 20853
Dunner, David Louis, 5620 Greentree Rd., Bethesda, Md. 20034

E

Eckhardt, Karl R., UCSD 225 W. Dickinson, San Diego, Calif. 92103
Edery, Esther, 1607 Dennis Ave., Baltimore, Md. 21204
Edlow, Donald William, 500 W. University Pkwy., Baltimore, Md. 21210
Egloff, Allen Clark, 4430 Post Rd., Apt. B-22, East Greenwich, R.I. 02818
Egnatinsky, Jack, 5 Mayo Ave., Annapolis, Md. 21403
Eiler, Donald Martin, 9308 E. Parkhill Dr., Bethesda, Md. 20014
Ein, Daniel, 7406 Wyndale Rd., Chevy Chase, Md. 20015
Epstein, Barry H., 92-15 Three Oaks Dr., Silver Spring, Md. 20901
Eren, Sacit, 529 S. Camp Meade Rd., Linthicum, Md. 21090
Ereshevich, Michael, 1118 4th St., Perry Point, Md. 21902
Etnoyer, John Joseph, 103 Legerton Lane, Lexington Park, Md.
Eymontt, Michael John, 536 College Pkwy., Rockville, Md. 20850

F

Farrell, Donald Francis, 241 E. Timonium Rd., Baltimore, Md. 21093
Fauci, Anthony Stephen, 2802 Olive St., N.W., Wash., D.C. 20007
Fauver, Howard Earl, Jr., 2629 N. Sycamore St., Arlington, Va. 22207
Feingold, Leonard Neil, 6144 E. Pratt St., Baltimore, Md. 21224
Feinsilver, David Baer, 3428 Oliver St., N.W., Wash., D.C. 20015
Feldman, Gary Ellis, 5017-D Green Mtn. Cr., Columbia, Md. 21043
Ferrer, Roberto Osvaldo, 338 Stevenson Lane, Apt. B-3, Towson, Md. 21204
Fischer, David John, 9727 Mt. Pisgah Rd., Silver Spring, Md. 20903
Fisher, Richard E., 719 Cotter Rd., Glen Burnie, Md. 21061
Flair, Robert Charles, 401 E. Indian Spring Dr., Silver Spring, Md. 20901
Flanigan, Richard John, 916 Bethany Ct., Annapolis, Md. 21403
Flannery, Eugene Patrick, 9205 Burley Dr., Bethesda, Md. 20034
Fleming, William Hare, 5105 Nahant St., Bethesda, Md. 20016
Flores, Luis Ricardo, P.O. Box 151, Crownsville, Md. 21032
Force, Judson Franklin, Jr., 204 Hopkins Rd., Baltimore, Md. 21212
Fortner, Robert William, 11604 Grandview Ave., Wheaton, Md. 20902
Foster, Alan Clifford, 1604 Dennis Ave., Silver Spring, Md. 20902
Frack, Herman, 806 Mapleton Ave., Oak Park, Ill. 60302
Freeman, John Mark, Dept. Neurology, Johns Hopkins Univ. Sch. of Med., Baltimore, Md. 21205
Freeman, William James, Johns Hopkins Hosp., Baltimore, Md. 21205
French, Johnny Boone, 10702 St. Margaret's Way, Silver Spring, Md. 20902
Freshman, Michael Earl, Kirk Army Hosp., Aberdeen, Md. 21005
Friedman, Barry Howard, 11235 Oak Leaf Dr., Silver Spring, Md. 20901
Friedman, Howard Ronald, 5912-D Cross Country Blvd., Baltimore, Md. 21215
Furst, William Kent, 419 Kettering Dr., Upper Marlboro, Md. 20870

G

Garcia, Dionisio Legaspi, Jr., 6931 McClean Blvd., Baltimore, Md. 21234
Garcia, Ignacio T., 705 Wicomico Ave., La Plata, Md. 20646

Garin-Vargas, Pura G., 4789 Walford Rd., Apt. 10, Warrensville Hts., Ohio 44128
Gehris, Clarence Winfred, Jr., 1531 McElderry St., Baltimore, Md. 21205
Gelfond, Stephen David, 520-A N. Bond St., Baltimore, Md. 21205
Gelin, John deCourtenay, 293 W. 31st St., Baltimore, Md. 21211
Gerry, Hubert Whitney, 5958 E. Pratt St., Baltimore, Md. 21224
Gershon, Elliot Sheldon, 2105 Glenallan Ave., Silver Spring, Md. 20906
Gibbas, Donna Lee, 1605 Summit Ave., Baltimore, Md. 21237
Gilman, Priscilla Ann, Univ. Hosp., 22 S. Greene St., Baltimore, Md. 21201
Ginzburg, Harold Myron, 526-B N. Bond St., Baltimore, Md. 21205
Givelber, Harry Michael, 9504 Hollins Ct., Bethesda, Md. 20034
Glickman, Robert Morris, 10118 Crestwood Rd., Kensington, Md. 20795
Glucksman, Myron Lawrence, 8815 Woodland Dr., Silver Springs, Md. 20910
Goldberg, Henry Israel, 2209 Greenery Lane, Silver Spring, Md. 20906
Goldman, Jerome Norman, 3201 33rd Pl., N.W., Wash., D.C. 20008
Goldsmith, Stanley, 5921 Western Run Dr., Baltimore, Md. 21209
Goldstein, Josef Jay, 225 Schilling Cr., Western Electric Co., Cockeysville, Md. 21030
Gondos, Bela, 8423 Donnybrook Dr., Chevy Chase, Md. 20015
Gonzalez-Revilla, Antonio, Jr., 550 N. Broadway, Baltimore, Md. 21205
Goodman, Julius M., University Med. Center, Div. of Neurosurgery, Indianapolis, Ind. 46202
Gordon, Bruce Lewis, 2233 Rogene Dr., Baltimore, Md. 21209
Gordon, Marvin J., 12 Mountbatten Ct., Apt. 204, Baltimore, Md. 21207
Gorelkin, Leo, 2400 Queens Chapel Rd., Apt. 403, Hyattsville, Md. 20782
Granoff, Paul Dennis, 1961 Green Berry Rd., Greenberry Woods, Balto., Md. 21209
Green, William Richard, 9708 Sherwood Ave., Baltimore, Md. 21204
Greenberg, Warren Mark, Apt. 10F, Concord Cove Apts., Chesapeake Dr., Havre de Grace, Md. 21078
Greenfield, Albert Aaron, 530 S. 24th St., Arlington, Va. 22202
Gudnason, Halldor Victor, 3702 Marlin Way, Annandale, Va. 22003
Gueriera, Charles Joseph, 6500 Elmdale Rd., Alexandria, Va. 22312
Guerzon, Rosario Guerzon, 4519 Cheltenham Dr., Bethesda, Md. 20014
Gurley, Hubert Taylor, 1921 Greenberry Rd., Baltimore, Md. 21209
Gutterman, Lorence Armon, P.O. Box 943, Edgewood, Md. 21040
Guzelian, Philip Samuel, Jr., 5800 Annapolis Rd., Bladensburg, Md.

H

Hadlock, Daniel Canfield, 6158 E. Pratt St., Baltimore, Md. 21224
Hall, Rowena Sidbury, 5620 Bent Branch Rd., Bethesda, Md. 20016
Hamblock, Leonard Charles, Box 185, Rt. 2, North East, Md. 21901
Hand, Bernard Richard, 3170 Hewitt Ave., Silver Spring, Md. 20906
Haney, Lucie Renee, Upper Glencoe Rd., Box 666, Glencoe, Md. 21152
Harlin, Joyce Ann, 334 Presway Rd., Timonium, Md. 21903
Harper, Jay Garland, 7104 Fernwood St., #2123, Richmond, Va. 23228
Harrell, James Earl, 4812 Bel Pre Rd., Rockville, Md. 20853
Harrer, David Stanley, 10103 Thornwood Rd., Kensington, Md. 20795
Hattwick, Michael Albert Walter, 6838 Walker Mill Rd., #301, District Hts., Md. 20027
Hausman, Marvin Stanley, 420 College Pkwy., Rockville, Md. 20850
Hazra, Tapan Aditya, 4920-D Crenshaw Ave., Baltimore, Md. 21206
Heard, Milton Gilbert, 1546 Cottage Lane, Baltimore, Md. 21204
Henderson, John McInnes, Sheppard-Pratt Hosp., Towson, Md. 21204
Hendrickson, Ronald Russell, Naval Hosp., Patuxent River, Md. 20670
Henry, George Madison, 5622 Greentree Rd., Bethesda, Md. 20034
Hernandez, Juan Bautista, 2215 Portland Ave., Louisville, Ky. 40212
Hernandez, Tomas, 611-L Cranbrook Rd., Cockeysville, Md. 21030
Herndon, Robert McCulloch, Dept. Neurology, Johns Hopkins Hosp., Balto., Md. 21205
Hess, Owen Richard, Peninsula Gen. Hosp., Salisbury, Md. 20801
Hickey, Timothy F., Jr., 11104 Jolly Way, Kensington, Md. 20795
Hill, Julius Napoleon III, 620 Americana Dr., #209, Annapolis, Md. 21304
Himmelhoch, Samuel Ralph, 18952 Whetstone Cr., Montgomery Village, Gaithersburg, Md.
Holcomb, Thomas Murray, 2026 Dumont Rd., Timonium, Md., 21093
Holden, Kenton Roy, 550 N. Broadway, Apt. 503, Baltimore, Md. 21205
Homayouni, Masud, 5203 Rayburn Dr., Camp Springs, Md. 20031
Horwitz, Norris Leonard, 7401 New Hampshire Ave., Hyattsville, Md. 20783
Houston, Frank Matt, 219 Brandon Rd., Baltimore, Md. 21212
Howell, Daniel Meredith, 132 W. Lafayette Ave., Baltimore, Md. 21217
Howie, Donald Lavern, 9302 Brookville Rd., Silver Spring, Md. 20910
Hubbard, Jeffrey Douglas, Balto. Cancer Research Center, 3100 Wyman Pk. Dr., Baltimore, Md. 21211

I

Imperial, Roland, 829 Westwood Blvd., Jackson, Michigan
Inderbitzin, Lawrence Ben, 11808 Auth Lane, Silver Spring, Md. 20902
Ipeker, Selahattin, 23951 Lake Shore Blvd., Apt. 713-B, Euclid, Ohio 44123
Irwin, David Stanford, 9900 Georgia Ave., Apt. 209, Silver Spring, Md. 20902

J

Jack, Joseph, Jr., Med. Dept. Bethlehem Steel Corp., Sparrows Point, Md. 21219
Jacobs, Leonard Steven, 568 College Pkwy., Rockville, Md. 20850
Jain, Sumer Chand, 9272 Edmonston Rd., Greenbelt, Md. 20770
Janoski, Alfonso Hubert, Univ. of Md. School of Med., Baltimore, Md. 21201
Jewell, May Gwendolyn Sirjoo, RR 2, Box 247, Hampstead, Md. 21074
Jezic, Dragan V., Greater Balto. Med. Center, 6701 N. Charles St., Balto., Md. 21204
Johnson, Stephen Leonard, 11 Knoll Ridge Ct., Baltimore, Md. 21210
Jones, David George, 20 Grandview Rd., Arnold, Md. 21012
Jones, Jacqueline, 1810 E. Monument St., Baltimore, Md. 21205
Jones, Kenneth Lee, 1517 E. Monument St., Baltimore, Md. 21205

K

Kane, James Gregory, Jr., Stevenson Road, Stevenson, Md. 21153
Kanner, Steven Philip, 5912 Cross Country Blvd., Baltimore, Md. 21215
Kaplan, Harold Jerome, 8206 Marcie Dr., Pikesville, Md. 21208
Karger, Stuart, P.O. Box 95, Edgewood, Md. 21040
Karr, Reynold Michael, Jr., Apt. 36, 15601 Tustin Village Way, Tustin, Calif. 92680
Katz, Harvey Paul, Columbia Hosp. & Clinics Foundation, 311 Teachers Bldg., Columbia, Md.
Katz, Ronald Alan, 11925 Parklawn Dr., Rockville, Md. 20852
Kaufman, Felix L., 6603 Bonnie Ridge Dr., Baltimore, Md. 21209
Kazazian, Haig Hagop, Jr., 221 Tunbridge Rd., Baltimore, Md. 21212
Keenan, Thomas Patrick, 3511 Silver Park Dr., Apt. 304, Suitland, Md. 20023
Kellum, John Morgan, 2018 McElderry St., Baltimore, Md. 21205
Kelly, John Michael, #21 Maryland Ave., Towson, Md. 21204
Khorsandian, Rostam Shahriar, Carmichaels Clinic, Carmichaels, Pa. 15320
Kim, Hyun Wha, 9404 Linden Ave., Bethesda, Md. 20014
Kirchner, Peter Thomas, U.S. Naval Hosp., Bethesda, Md. 20014
Kirschner, Leslie Gordon, Jr., 5225 Conn. Ave. N.W., Suite 705, Wash., D.C. 20015
Klein, Harvey Gordon, 1515 McElderry St., Baltimore, Md. 21205
Knefely, George McLanahan, Jr., 616 Dunkirk Rd., Baltimore, Md. 21212
Kneller, Martin Stanley, 8347 Donnell Pl., Forestville, Md. 20028
Koh, Ey Kol, 4407 La Plata Ave., Baltimore, Md. 21211
Kokolis, Panagis Spirou, Phila. State Hosp., Philadelphia, Pa. 19116
Kolodny, Roselyn Leinwand, 345 Congressional Lane, Rockville, Md. 20852
Kolsky, Neil Harris, Johns Hopkins Hosp., 601 N. Broadway, Balto., Md. 21205
Kornreich, Leonard Michael, 1110 Fidler Lane, Silver Spring, Md. 20910
Kosinski, Edmund John, 528 Beall Ave., Rockville, Md. 20850
Kosnik, Edward James, Jr., 622 W. 168th St., New York, N.Y. 10032
Kotchen, Theodore Allan, 4 Franklin Ave., Silver Spring, Md. 20901
Kowarski, Avinoam, 6501 Copper Ridge Dr., Baltimore, Md. 21209
Kraus, Jeanne Smith, 6 Revell Rd., Round Bay, Severna Park, Md. 21146
Krone, Howard Barry, 5811 Fisher Rd., Apt. 102, Oxon Hill, Md. 20031
Kuehl, Karen Simpson, 4970 Battery Lane, Bethesda, Md. 20014
Kuzucu, Ethem Yildirim, 622 Stevenson St., Sayre, Pa. 18840

L

Laing, Vern Odean, 10403 Brunswick Ave., Silver Spring, Md. 20902
Lao-Iff, Anita, 10119 Brunswick Ave., Silver Spring, Md. 20902
Lareau, Eugene Raymond, 4910 Crescent St., Bethesda, Md. 20016
Larson, Alvin Leroy, 12411 Stonehaven Lane, Bowie, Md. 20715
La Vina, Claro Lipayon, 2 Dalecrest Ct., Timonium, Md. 21093
Lawrence, Donald Peter, 651 Alliance St., Havre de Grace, Md. 21078
Lee, Uriel A., 5308 2nd St., N.W., Wash., D.C. 20011
Leftwich, Ezalia Ida, 236 Longfellow St., N.W., Wash., D.C. 20011
Lemberger, Louis, 8404 Thornden Terr., Bethesda, Md. 20034
Levinson, Arnold I., 6108 E. Pratt St., Baltimore, Md. 21224
Levitsky, Lynne Lipton, 10327 Royal Rd., Silver Spring, Md. 20903
Levy, Charles Earl, 6607 Copper Ridge Dr., Apt. T-1, Baltimore, Md. 21209
Levy, Ronald Melvyn, 3015 Ellerslie Ave., Baltimore, Md. 21218
Lieberman, Norman Allen, 6411 Greyfield Rd., Fayetteville, N.C. 28303
Light, Richard Wayne, 1504 McElderry St., Baltimore, Md. 21205
Lindeman, Robert John, Wildwood Med. Bldg., 10401 Old Georgetown Rd., Bethesda, Md. 20014
Little, Raymond Roger, 35 Old Sound Rd., Joppatowne, Md. 21085
Llera, Rene A., Springfield St. Hosp., Sykesville, Md. 21784
Lodmell, John Gary, 10503 Brunswick Ave., Silver Spring, Md. 20902
Lowe, Edward Joseph, 7722 Maple Ave., Takoma Park, Md. 20012
Lowery, Samuel, 1086 Franklin St., Johnstown, Pa.
Lukensmeyer, William Wendall, 5759-E Hazelwood Cr., Balto., Md. 21206
Lustig, Herbert Selig, 6128 E. Pratt St., Baltimore, Md. 21224
Lutz, Michael David, 605 N. Caroline St., Baltimore, Md. 21205
Luz, Pablito Simbol, 2 Nevin Terr., Easton, Pa. 18042

M

McConnaughy, Richard Allen, 202 Gina Ct., Oxon Hill, Md. 20021
McDermott, William Michael, Jr., 5314 Bangor Dr., Kensington, Md. 20795
McElfatrick, George Charles, 2006 Ramblewood Rd., Baltimore, Md. 21214
McElroy, Betty Howell, 5600 Bent Branch Rd., Bethesda, Md. 20016
McGowan, Larry, 7625 May Cassatt Dr., Potomac, Md. 20854
McGrail, John Francis, Naval Hosp., Camp Lejeune, N.C. 28542
McKhann, Guy Mead, Dept. Neurology, Johns Hopkins Hosp., Balto., Md. 21205
McNeely, Warren David, 9805 Hillridge Dr., Kensington, Md. 20795
MacDonald, Gerard Fintan, 3730 Univ. Ave., N.W., Wash., D.C. 20016
MacDonald, Robert James, 2800 Strathmore Ave., Balto., Md. 21214
Magassy, Csaba Ladislao, 10500 Rockville Pike, #220, Rockville, Md. 20852
Mahajan, Raghbir Singh, 3207 Toledo Plaza, #201, Hyattsville, Md. 20782
Mahajan, Shakuntla Devi, 3207 Toledo Plaza, #201, Hyattsville, Md. 20782
Majzoub, Hisham Salem, 1285 Broadview Ave., Morgantown, W. Va. 26505
Mallin, Bruce Arnon, Univ. Hosp., Balto., Md. 21201
Mansouri, Karim, 3333 University Blvd. W., Kensington, Md. 20795
March, Allan Wayne, 4811-A Bayonne Ave., Baltimore, Md. 21206
Marcus, Melvin Lenard, 454 College Pkwy., Rockville, Md.
Marine, Robert Marion, Prince George's Hosp., Cheverly, Md. 20785
Maybee, David Alan, 10001 Raynor Rd., Silver Spring, Md. 20901
Mazocco, Victor Eugene, 912 Seton Dr., Cumberland, Md. 21502
Meghdadi, Gholamali, 4182 #6 Faronia, Memphis, Tenn. 38116
Mendez, Hector Cortes, Rt. 7, Box 24-A, Westminster, Md. 21157
Meshel, Jack C., P.O. Box 137, William Beaumont Gen. Hosp., El Paso, Texas 79920
Michalko, Charles Harold, Rt. 2, Box 134-D, Hollywood, Md.
Michelson, Alfred, Sheppard-Pratt Hosp., Towson, Md. 21204
Mihalakis, Isidore, 2006 Helmsby Rd., Baltimore, Md. 21228
Miller, Franklin John, Jr., RD #2, Hegins, Pa. 17938
Miller, Joseph Matthew, V.A. Hosp., Ft. Howard, Md. 21052
Milne, Milton Jerome, 5403 16th Ave., W. Hyattsville, Md. 20782
Mistrot, Jean Jacques, 606 N. Bond St., Baltimore, Md. 21205
Montell, Edwin Michael, 723 Lewis St., Havre de Grace, Md. 21078
Moreno, Orlando, 4246 Three Oaks Dr., Silver Spring, Md. 20901
Morris, Jed Lane, 2006 Broadway, #306, Nashville, Tenn. 37203
Mott, Peter Dodge, 2310 Ken Oak Road, Baltimore, Md. 21209

Mould, Thomas Mathew, 5114 Battery Lane, Bethesda, Md. 20014
Moxley, John Howard, III, Univ. of Md. School of Medicine, Balto., Md. 21201
Murphy, Frederick Patrick, #3 Pooks Hill Rd., Bethesda, Md. 20014
Murphy, Kenneth Francis, U.S. Naval Academy, Bldg. K-5, Annapolis, Md.

N

Negrey, John Nicholas, Jr., A-10307 Malcolm Cr., Cockeysville, Md. 21030
Neill, Jeffrey David, 1523 McElderry St., Baltimore, Md. 21205
Nelson, Bradley Wimmer, 7730 Maple Ave., Takoma Park, Md. 20012
Neshat, Amir Ali, 723 E. Lake Ave., Baltimore, Md. 21212
Nettles, Harry Heyward, 7009 11th St., N.W., Wash., D.C. 20012
Neviaser, Jules S., 1918 K St., N.W., Wash., D.C. 20006
Newberg, Lewis Barry, 2429 N. 111th St., Wanwatosa, Wisconsin 53226
Newman, Alvin, 110 W. 39th St., Balto., Md. 21210
Newman, Gordon Harry, 11235 Oak Leaf Dr., Silver Spring, Md. 20901
Nieder, Joseph Martin, 9727 Mt. Pisgah Rd., Silver Spring, Md. 20903
Noel, Patrick A., 525 Thayer Ave., Silver Spring, Md. 20910
Northrup, Bruce Edgar, 538-B N. Bond St., Baltimore, Md. 21205
Notarangelo, Joseph Domenic, 427 Gusryan St., Baltimore, Md. 21224
Nothmann, Bruce Joseph, 6100 E. Pratt St., Baltimore, Md. 21224
Nover, Robert Allen, 10725 Bucknell Dr., Silver Spring, Md. 20902
Nyman, Gary William, 1518 Park Ave., Baltimore, Md. 21217

O

O'Brien, David Shepard, Dept. Radiology, Anne Arundel Hosp., Annapolis, Md. 21401
O'Croinin, Proinnsias, Pediatrics, USAHCZJ, APO San Francisco, Calif. 96343
O'Keefe, Edward John, 10915 Montrose Ave., Garrett Park, Md. 20766
O'Kieffe, Donald Ary, 5167 Linnear Terr., N.W., Wash., D.C. 20008
O'Leary, Dennis Sophian, 6108 Wynnwood Rd., Wash., D.C. 20016
Oliver, Cap Hill, Jr., 1101 Cottage St., S.W., Vienna, Va. 22180
Olsen, Charles Thomas, 331 Congressional Lane, Rockville, Md. 20852
O'Regan, Thomas Joseph, 9338 Edmonston Rd., Greenbelt, Md. 20770
Osborn, Lawrence William, 12720 Twinbrooke Pkwy., Rockville, Md. 20852
Oser, Irnest Stephen, 11550 Lockwood Dr., Silver Spring, Md. 20904
Ostroff, Morris, 3020-A Fallstaff Manor Ct., Baltimore, Md. 21209

P

Padgett, William Neil, Jr., Quarters 5, Naval Hosp., Annapolis, Md. 21402
Palad, Consolador Cruz, Jr., 5517 Hamilton Ave., Balto., Md. 21206
Parra, Celiar E., V.A. Hospital, Ft. Howard, Md. 21052
Parris, Herbert Arthur, 2908 Northview Dr., Youngstown, Ohio 44504
Patel, Nagindas Lalloobhai, 3707 Guilder La., Richmond, Va. 23234
Patel, Urmila M., 9185 Springhill Lane, Greenbelt, Md. 20770
Paul, Malcolm David, 5700 Arlington Ave., Apt. 21-F, Riverdale, N.Y. 10471
Paul, Michael Ian, 5423 McKinley St., Bethesda, Md. 20034
Pearson, Frederick Norman, 110 W. 39th St., Baltimore, Md. 21210
Peck, Alan H., 1601 Bolton St., Balto., Md. 21217
Pedersen, Paul Richard, 10813 Jewett St., Silver Spring, Md. 20902
Perkins, Walter Reams, Jr., 6913 Southridge Dr., McLean, Va. 22101
Pesikoff, Richard Bernard, 114 Hesketh St., Chevy Chase, Md. 20015
Phillips, Joseph Donald, Univ. Towers, Apt. 1212, Silver Spring, Md.
Phillips, Roland Lee, 6727 Windsor Mill Rd., Baltimore, Md. 21207
Pierson, Dean Lawrence, 10506 Glen Haven Dr., Silver Spring, Md. 20902
Polak, Teodor, 443 Greencraig Rd., Los Angeles, Calif. 90049
Pope, William Wade, 601 N. Caroline St., Baltimore, Md. 21205
Postman, Louise Yood, 7112 Edgevale St., Chevy Chase, Md. 20015
Pratt, Alan Goodale, 2501 Plyers Mill Rd., Silver Spring, Md. 20902
Proctor, Herbert Jennings, 313 Cedar Lane, Rockville, Md. 20851

R

Rafii, Amir, 3 Raven Rock Ct., Richmond, Va. 23229
Ramirez, Carlos Manuel, 611-A Cranbrook Rd., Cockeysville, Md. 21030
Raphling, David Leon, 5225 Connecticut Ave., N.W., Washington, D.C. 20015
Rawlings, Nina Cole, 153 N. Edgewood St., Baltimore, Md. 21229
Reale, Vincent Francis, 550 N. Broadway, Apt. 906, Baltimore, Md. 21205
Reaud, Angel, 1818 Metzerott, Apt. 26, Adelphi, Md. 20783
Reinstein, Leon, 325-F Brentwood Dr., York, Pa. 17403
Renjel, Luis Eduardo, 7 Debonair Ct., Baltimore, Md. 21234
Resnik, Harvey Lewis Paul, 4701 Willard Ave., Chevy Chase, Md. 20015
Riley, David Joseph, 4940 Eastern Ave., Baltimore, Md. 21224
Robertson, Robert Brewer, 258 Broad St., Red Bank, N.J. 07701
Roemer, Peter Anthony, 1708 Flora Lane, Silver Spring, Md. 20910
Rollins, Stacy Linton, Jr., 6408 Brookside Dr., Chevy Chase, Md. 20015
Roos, Raymond Philip, 19000 #5 Mills Choice Rd., Montgomery Village, Gaithersburg, Md. 20760
Rosenberger, Eugene A., 11515 Lovejoy St., Silver Spring, Md. 20902
Rosenfeld, Michael Geoffrey, 8332 Draper Lane, Silver Spring, Md. 20910
Rosenfield, Arthur Ted, 110 W. 39th St., Baltimore, Md. 21210
Rosenthal, Harry Hugh, 516 E. Indian Spring Dr., Silver Spring, Md. 20901
Roth, Sheldon, 6909 Wilson Lane, Bethesda, Md. 20034
Ruben, Harvey Lee, 2005 Coleridge Dr., Apt. 201, Silver Spring, Md. 20902
Rubin, Peter Erwin, 4548 N. Charles St., Baltimore, Md. 21210
Ruggiero, Novello Egidio, 916 19th St., N.W., Suite 401, Wash., D.C. 20006
Rushing, Stephen Orren, 1621 Bolton St., #3, Baltimore, Md. 21217
Rutland, Andrew, 1577 Henry St., Melbourne, Fla.

S

Saba, George Peter II, 518 Kerwin Rd., Silver Spring, Md. 20901
Sabatier, Henry S., 2065 Adelbert Rd., Cleveland, Ohio 44106
Saeed, Mohammad Khubaib, 925 N. 12th St., Allentown, Pa. 18102
Saltzman, Donald Irwin, 5950 E. Pratt St., Baltimore, Md. 21224
Santiano, Jesus Gillego, 907 Walnut St., Pocomoke City, Md. 21851
Santilli, John, Jr., 9612 Dilston Rd., Silver Spring, Md. 20903
Sappington, Thomas Stone, 3546 Raymoor Rd., Kensington, Md. 20795
Sargent, Robert Anders, 4315 N. 31st St., Arlington, Va. 22207
Sasamori, Toshio, 753 Galliton Lane, Towson, Md. 21204
Schader, Robert Burton, 3103-A Walnut St., Dover, Delaware 19901
Schermer, Donald Richard, 2241 Rogene #202, Baltimore, Md. 21209
Schlossberg, Barry Joel, 5002 Corley Rd., Apt. C-1, Balto., Md. 21207
Schmidt, Robert William, 2047 Woodbourne Ave., Balto., Md. 21214
Schneider, Ronald L., North Shore Hosp., Manhasset, N.Y. 11030
Schneider, Victor Sidney, U.S.P.H.S. Hosp., 3100 Wyman Park Dr., Balto., Md. 21211
Schneiderman, Charles Isaac, 1111 Univ. Blvd., West, Silver Spring, Md. 20902
Schwarz, Eitan Daniel, 45 Marion St., Brookline, Mass. 02146
Sendi, Houchang, 4728 Kenmore Ave., Alexandria, Va. 22304
Seremetis, Michael George, 1234 19th St., N.W., Wash., D.C. 20036
Shah, Naren N., 5101 River Rd., Bethesda, Md. 20016
Sharrett, Albert Richey, 1019 Oak Hill Ave., Hagerstown, Md. 21740
Shawker, Thomas H., 253-F Woodmill Dr., Glen Burnie, Md. 21061
Shaz, Sol, 3001 Branch Ave., #104, Wash., D.C. 20031
Sheedy, John Austin, 1800 Dumbarton St., McLean, Va. 22101
Sherwin, Barbara Ensfield, 1829 23rd St., N.W., Wash., D.C. 20008
Shin, Moon Lee, 20 Gunpowder Rd., Baltimore, Md. 21234
Shobin, David Michael, 3411 Wayne Ave., Apt. 3-F, Bronx, N.Y. 10467
Sickler, Donald Prenier, 11542 Lockwood Dr., Silver Spring, Md.
Sickler, Sarah Yacono, Youngstown Hosp. Assoc., Oak Hill, Youngstown, Ohio 44501
Silbergeld, Sam, 10704 Clermont Ave., Garrett Park, Md. 20766
Sills, Edward Martin, 1902 Greenberry Rd., Baltimore, Md. 21209
Silverman, Nira Rubin, 5518 Southwick St., Bethesda, Md. 20034
Silverstein, Martin Barry, 116 Lynn Dr., Lexington Park, Md. 20653
Singca, Edmundo G., 213-C Atholgate Lane, Baltimore, Md. 21229
Singh, Raghbir, Lynchburg Training Sch. & Hosp., Lynchburg, Va. 24505
Skitarelic, Kathryn Frances, Route 9, Cumberland, Md. 21530
Smith, Sara Watt, 6617 English Oak Rd., Apt. 2, Baltimore, Md. 21234
Snyder, Bernard Melvin, 101 Biltmore Dr., Colonial Heights, Va. 23834
Sobel, Harold John, 105 Herrick Rd., Wayne, N.J. 07470
Sobhany, Manochehr, 2222 Georgian Wood Pl., Wheaton, Md. 20902
Sohr, William Eric, 4402 Colborne Rd. #1, Baltimore, Md. 21229
Solan, George Miley, 949 Seton Drive, Apt. 5, Cumberland, Md. 21502
Spangler, Donald Bruce, 1228 Northview Rd., Baltimore, Md. 21218
Spielman, Stuart Henry, 8500 Stevenson Rd., Baltimore, Md. 21208
Spivak, Jerry LePow, 10375 Barcan Cr., Columbia, Md. 21043
Stanzione, Steven Joseph, 5110 Wilson Lane, Bethesda, Md. 20014
Steinglass, Peter Joseph, 9250 Edmonston Rd., Greenbelt, Md. 20770
Steinman, Robert Charles, 8811 Liberty Lane, Potomac, Md. 20854
Stern, Melvin Joseph, 539 E. Indian Spring Dr., Silver Spring, Md. 20901
Stern, Michael Paul, 3402 Cameron Mills Rd., Alexandria, Va. 22305
Stiglitz, Mark Lawrence, 4804 Chevy Chase Blvd., Chevy Chase, Md. 20015
Strauss, Albert John, Jr., 810 Fountain Head Rd., Hagerstown, Md. 21740
Strauss, Arthur Joseph Louis, 1301 Karen Blvd., Apt. 103, District Hts., Md. 20027
Stuart, Franklin Richard, 24-J, Ridge Rd., Greenbelt, Md. 20770
Subong, Anastacio E., Jr., 8249-A Kramer Ct., Village Sq., Glen Burnie, Md. 21061
Sugar, Mark S., 780 E. Gilbert St., San Bernardino, Calif. 92404
Sullivan, Mary Ann, 3019 Northway Dr., Baltimore, Md. 21234
Summer, Warren Richard, 2121 Shorefield Rd., Wheaton, Md. 20902
Sussman, Michael David, c/o Biophysics Dept., Gerontology Research Center, NIH, NICHD, Balto. City Hosps., Balto., Md. 21224
Sutherland, John Campbell, 1013 Roxleigh Rd., Baltimore, Md. 21204

T

Tanguilig, Lory Estella, Provident Hosp., Baltimore, Md. 21217
Tate, Harry Randolph, 2501 Johnston Ct., Virginia Beach, Va. 23454
Taylor, Charles Earl, 5176 Eliot's Oak Rd., Columbia, Md. 21043
Thomas, Terrence Joseph, 965 E. High St., Oakland, Md. 21550
Thorne, Jean Musey, 2015 W. Rogers Ave., Baltimore, Md. 21209
Tigertt, William David, 2307 Two Charles Center, 8 Charles Plaza, Baltimore, Md. 21201
Tockman, Melvyn Seymour, 5942 E. Pratt St., Baltimore, Md. 21224
Tolentino, Ernesto Anibal, 87 Fulton Ave., Jersey City, N.J. 07305
Tramont, Edmund Clement, 4611 Chestnut St., Bethesda, Md. 20014
Troner, Michael Barnet, 2505 Gatehouse Dr., Baltimore, Md. 21207
Turek, Alice Jaros, 5006 Washington Blvd., Arlington, Va. 22205
Turney, Stephen Zachary, 320 Morris Ave., Lutherville, Md. 21093

U

Ullman, Kenneth Charles, 11235 Oak Leaf Dr., Apt. 1913, Silver Spring, Md. 20901
Utz, Daryl W., 11 Schermerhorn St., Brooklyn Hts., N.Y. 11217

V

Vagley, Richard Thomas, 1600 S. Eads St., Apt. 1003-N, Arlington, Va. 22202
Van Kirk, Owen Charles, 9348 Cherry Hill Rd., Apt. 723, College Park, Md. 20740
Vermillion, Robert Lee, 550 N. Broadway, Apt. 1004, Baltimore, Md. 21205
Voelkel, Paul Brown, Box 26411, Grady Memorial Hosp., Atlanta, Ga. 30303

W

Wall, Haven Neill, Jr., 111 W. Centre St., Apt. 1004, Baltimore, Md. 21201
Weil, Andrew Thomas, 5454 Wisconsin Ave., Chevy Chase, Md. 20015
Weinstock, Alan Robert, 167 Westway Rd., Greenbelt, Md., 20770
Weiss, Peter, 6316 Green Spring Ave., Baltimore, Md. 21209
West, John Michael, Box 197, Johns Hopkins Hosp., Baltimore, Md. 21205
White, Daniel Henry, 411 Tanglewood Ct., Joppa, Md. 21085
Wilder, Bruce Lord, 2002 Two Charles Center, 15 Charles Plaza, Baltimore, Md. 21201
Williams, Christine Lundberg, 4400 East West Highway, #132, Bethesda, Md. 20014
Williams, Daniel Herbert, 10115 Day Ave., Silver Spring, Md. 20910

Williams, George Melville, Bomont Rd., R.D. 1, Box 45, Lutherville, Md. 21093
Willmuth, Lewis Ragon, 960 N. Hill Rd., Baltimore, Md. 21218
Wilner, Elliot Charles, 5225 Conn. Ave., Wash., D.C. 20015
Wilson, John Wesley, 179 Reynolds Mill Rd., York, Pa. 17403
Wilson, W. Stan, 439 Greenwich #8-B, San Francisco, Calif. 94133
Winslow, Walter William, 9255 Three Oaks Dr., Silver Spring, Md. 20901
Winter, Stephen Lee, 12 Nightingale Way, Lutherville, Md. 21093
Wolfe, Hubert Joseph, 1845-B Kings Place, Frederick, Md. 21701
Wong, Wai Tuen, 7700 Mary Casatt Dr., Rockville, Md. 20854
Wood, Ernest M., 2 Fillmore, Cherry Point, N.C. 25833
Wray, William Swope, Area Med. Dir., Amer. Red Cross, Eastern Area, 615 N. St. Asoph St., Alexandria, Va. 22314
Wright, Peter Franum, 4805 Ertter Dr., Rockville, Md. 20853

Y

Yannakakis, George D., 6609 Bonnie Ridge Rd., Baltimore, Md. 21209
Yolles, Stanley Fausst, 5206 Locust Ave., Bethesda, Md. 20014

Z

Zahir, Muhammad, 22 S. Greene St., Baltimore, Md. 21201
Zaret, Barry L., 6601 Copper Ridge Dr., Baltimore, Md. 21209
Zvargulis, Janis E., 120 Ruskin Ave., Apt. 115, Pittsburgh, Pa. 15213

WHEN YOUR PATIENTS NEED NURSING CARE



Call Milton 4-6060

Alice Weber

Baltimore Nurses Exchange

LICENSED & BONDED

24 HOUR SERVICE ESTABLISHED 1935

BALTIMORE, MARYLAND 21229

OVER 60 YEARS OF FRIENDLY SERVICE

ARUNDEL FEDERAL

SAVINGS AND LOAN ASSOCIATION

ORGANIZED 1906



WHERE YOU SAVE DOES MAKE A DIFFERENCE

DIRECT REDUCTION HOME LOANS

Hours 9 A.M. to 2 P.M. Daily

Tuesday Evenings 7 to 9

355-9300

PATAPSCO AVENUE & FOURTH STREET

Baltimore, Maryland, 21225

Growing Feet Can Have Problems!



PRONATION KNOCK-KNEES PIGEON-TOES

These common problems can be helped with proper shoes, correctly fitted.

Prescriptions Carefully Filled

VAN DYKE & BACON

307 N. Charles St. SAratoga 7-3775

5849 York Rd. IDlewood 3-1100

Baltimore, Maryland

DOCTORS' OFFICES

LARGE

MEDIUM

SMALL

MEDICAL OFFICE BLDG.

REASONABLE RENT

ELEVEN E. CHASE ST. CORPORATION

11 E. Chase St.

Phone 539-8553

NOW
A NEW CONCEPT
in
BOOKKEEPING
and
TAX SERVICES

This Service, used by hundreds of Professional men in Maryland, is proof that we save time and money for you.

WHAT YOU DO —

Maintain a checkbook—one which we have especially designed for Physicians

WHAT WE DO —

—we prepare MONTHLY STATEMENTS of Income and Expense

—we prepare QUARTERLY AND FINAL PAYROLL RETURNS

—we prepare and adjust QUARTERLY DECLARATIONS OF ESTIMATED TAXES

—we prepare STATE AND FEDERAL INCOME TAXES, ready for signature

—we prepare a CONFIDENTIAL COST ANALYSIS

—we relieve you of the burden of BOOKKEEPING AND TAXES and leave you free to practice medicine.

FOR COMPLETE INFORMATION, with no obligation, call or write

SECURITY BUSINESS SERVICES, INC.

Box 335
Randallstown, Maryland *Tel.* 655-2552

K. Merrill Sumey, Resident Manager

Come Out to TOWSON and You'll come out On Top!

The big reason for coming to Towson Ford is not merely the location – it's the treatment you get. We handle our customers with TLC . . . we believe people should be treated like people! We offer the best deal right at the start, and back up what we say.

Choose from one of America's largest selections of new Fords, Torinos, Mustangs, Mavericks, & T-Birds. We'll keep your car & your budget in the best of health!

TOWSON FORD

900 blk. YORK RD.
S. from Beltway Exit 26
PHONE VA. 3-3131

Free your secretary for active duty.

You save precious secretarial time (and money) when your accounts receivable are handled electronically and expertly by Professional Systems and Services. In no time at all we teach your secretary to operate the compact IBM desk transmitter that speeds patient transactions to our data processing facility via commercial telephone lines. Then PS&S prepares and sends out your monthly statements and provides you with daily and monthly reports so that you and your accountant can keep accurate track of things. Speeds collections, too. Contact us now for a demonstration. And free your secretary to be your secretary again.

professional systems and services *division of*

Computer Center, Inc.
423 West Monument Street
Baltimore, Maryland 21201
728-3886



THE MONTH IN WASHINGTON

An American Medical Association spokesman outlined the **AMA's voluntary national health insurance plan, "Medicredit,"** for consideration by the House Ways and Means Committee.

Russell B. Roth, MD, speaker of the AMA's House of Delegates, and a practicing physician in Erie, Pa., said the plan which would be financed in part by federal income tax credits, is flexible and would assure all Americans —no matter how limited their financial resources—of adequate health care protection.

"Representing this country's physicians as we do," Dr. Roth said, "the AMA is on record in its belief that it is the basic right of every citizen to have available to him good health care.

"Today we want to put before this committee a plan which is universal in scope, voluntary in nature, and realistic in terms of total program cost."

Dr. Roth estimated the program would cost the federal government $8 billion to $9 billion a year, but about $3 billion a year of that would be offset by liquidation of the medicaid program. Medicare would continue.

"For those in low-income categories, this protection is theirs without expense or contribution on their part," Dr. Roth stated. "For those with moderate and higher levels of income, Medicredit provides a system of cash incentives to enable them to protect themselves against major health care costs. . . .

"Our proposal is the result of years of careful study of our existing mechanisms for delivering and financing health care, coupled with our close study of the federal government's ability to fund a universal health insurance program. . . .

"It would give to persons who have purchased comprehensive health insurance the option of receiving a tax credit on their annual federal income tax return, a credit based on their tax liability. That is, a taxpayer could take as a credit against the amount of income tax owed to the federal government, all or part of their personal cost for comprehensive health coverage. Persons or families with a lower tax liability (usually reflecting lower income or more dependents and allowable expenses) would receive a greater tax credit. And those families in the lower 30% income range, would, without cost to them, receive a certificate enabling them to purchase health coverage from qualified groups or plans."

The AMA plan calls for establishment of a "Health Insurance Advisory Board" to create Medicredit guidelines. It would be chaired by the Secretary of Health, Education, and Welfare and include the Commissioner of Internal Revenue and public members. It would review the effectiveness of the program and file annual reports with the President and the Congress.

Basic medical benefits of Medicredit would include:

—Up to 60 days of inpatient hospital services, including maternity services;

—All emergency room and outpatient services provided in the hospital;

—All physicians' services, whether performed in the hospital, home, office or elsewhere.

Supplemental benefits to basic coverage would also be eligible for tax credits.

Dr. Roth stressed the importance of utilizing private insurance carriers, thus taking maximum advantage of private sector competition to help hold costs down.

Rep. Durward G. Hall, MD (R., Mo.), a former member of the AMA House of Delegates, submitted to the committee another national health insurance plan. The first part of his two-part plan calls for the federal government to furnish persons eligible for medicaid with health insurance certificates covering certain specified basic health protection. The states would have the responsibility for the balance of health care for an eligible individual after his basic coverage had been exhausted. Thus, the Hall plan would replace medicaid.

The second part of the Hall proposal calls for the federal government helping, in cases of catastrophic illness, those persons who can afford normal health care insurance only.

Other national health insurance plans are being sponsored by Walter Reuther, head of the automobile workers' union; the AFL-CIO; Sen. Jacob K. Javits (R., N.Y.), and Gov. Nelson Rockefeller of New York. Indications are that the committee will not give serious consideration to such legislation before next year, at the earliest. However, it appears probable that the issue will come to a vote in Congress before the 1972 elections.

* * *

The AMA also submitted to the Ways and Means Committee a statement on the Nixon Administration's **"Health Cost Effectiveness Amendments of 1969" legislation.**

The AMA commended the Department of Health, Education and Welfare for its efforts to curtail the rising costs of medicaid and medicare, but said that the Association believes "there are better and more appropriate means of meeting this problem."

As for the provision prohibiting payment to physicians who have committed fraud, overcharged or otherwise abused the medicare program, the AMA said:

"It should be kept in mind that there presently exist remedies to reach the cases of abuse which may exist—certainly the cases of extreme abuses which HEW has asserted these proposed penalties are intended to reach. While it is true that the law does not provide authority to disqualify physicians as to prospective participation, a carrier may reject or review a physician's claims on an individual basis as each claim is presented.

"The apparent concern of the Congress regarding alleged abuses and increasing program costs may require some changes in the administration of federally financed health care programs. However, the proposed amendments appear to introduce more severe remedies than the problems require."

As for the provision that utilization review committees pass retroactively on the medical necessity of admission of medicare patients to hospitals, the AMA said:

"At the present time a utilization review plan of an institution must provide for review—on a sample basis or other basis—of admissions, duration of stays, and services furnished, and also must provide for review of each case of extended stay, and determine the medical necessity of further stay. The law provides for three additional days of benefit payments after a negative finding and notification.

"Where a finding has been made that the admission was unnecessary, no payment would be made. Thus the denial of payment would be retroactive to the date of admission. The three-day grace period is removed from existing law.

"The AMA previously objected to initial certification of the need for admission to a hospital, and this initial certification requirement was removed from the law. Under this bill, the utilization review committee would be required to review the attending physician's judgment as to the need for hospitalization. The present requirement of the committee under medicare is to review extended stay cases to determine the need for further stay; thus it does not review a great number of cases of hospitalization where the patient is discharged earlier. Requiring committees to review all cases of hospitalization would impose a tremendous burden on the committee, and create additional heavy demands on physicians' productive man hours.

"An adverse finding by a committee would subject the patient to individual liability for hospital charges. As a result, this provision could act as a restraint on patients receiving care, particularly in those cases where a physician recognizes the possibility of differing medical judgments concerning the admission."

Early in November, the Senate Subcommittee on Constitutional Rights heard **Mildred Mitchell-Bateman, MD, and John Donnelly, MD, members of the AMA's Council on Mental Health, present AMA information on the constitutional rights of the mentally ill.**

Dr. Bateman outlined many of the problems in preserving the civil rights of the mentally ill. Dr. Donnelly concluded the association's joint presentation with the statement, "The rationale for commitment is protection of the individual from himself, and protection of society from the individual. The consequences of commitment is, or should be, treatment—treatment of the mental illness which caused the individual to be harmful to himself and to others. . . . No man whose illness does not constitute a distinct threat to his welfare or to that of others should be forced to undergo treatment."

* * *

Appearing before the Select Subcommittee on Labor of the House Education and Labor

It's not too soon to make reservations for
Med-Chi's Annual Meeting
April 1, 2, 3, 1970
Call or write the Faculty office for information

Committee, **R. Lomax Wells, MD, a member of the AMA's Council on Occupational Health, offered the association's support of the Administration's Occupational Safety and Health Act, H.R. 13373.**

Dr. Wells, speaking for the AMA, supported the creation of the Presidentially appointed five-man National Occupational Safety and Health Board whose function it would be to set national occupational safety and health standards, and to create a National Advisory Committee which would permit active participation by the Department of HEW.

He also stated the AMA's support for increased federal funding of state occupational safety and health programs for the purposes of upgrading state programs, so that they might eventually take over the responsibility for the promulgation and enforcement of state standards in place of the federal program.

* * *

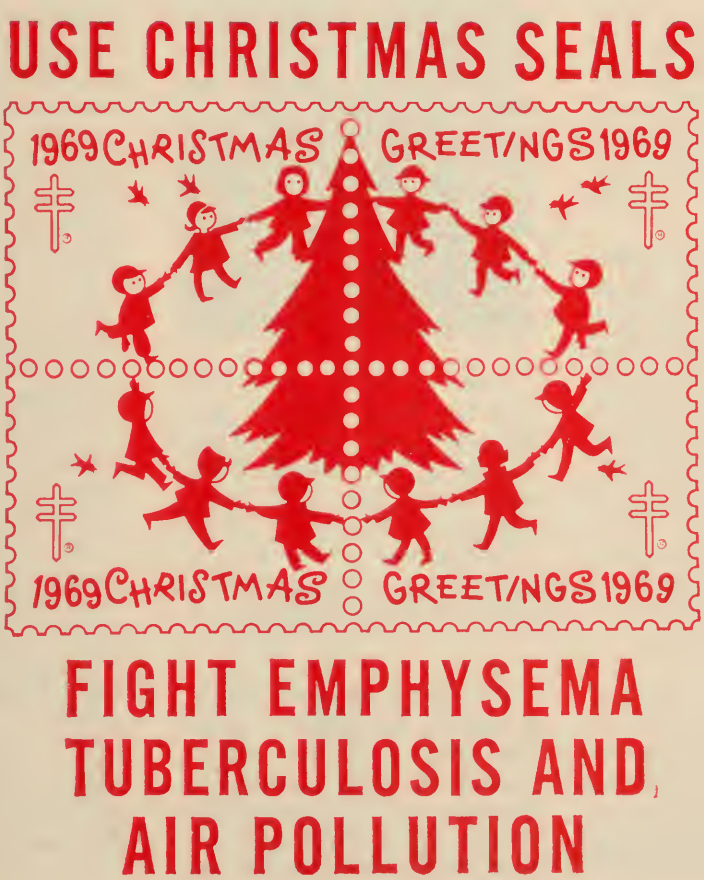
President Nixon, in his message to Congress on Consumer Affairs and Protection, stressed the need for "stronger efforts in the field of food and drug safety." He suggested a re-evaluation of the Food and Drug Administration, and a review of the products on the "generally regarded as safe" list.

In speaking of drugs, the President said that he would ". . . recommend that the Congress take action which would make possible, for the first time, the rapid identification of drugs and drug containers in a time of personal emergency." (The AMA has supported adequate labelling of prescription containers and has drafted a bill to that effect.)

The President went on to say, "Another important medical safety problem concerns medical devices—equipment ranging from contact lenses and hearing aids to artificial valves which are implanted in the body. Certain minimum standards should be established for such devices; the government should be given additional authority to require premarketing clearance in certain cases. The scope and nature of any legislation in this area must be carefully considered, and the Department of HEW is undertaking a thorough study of medical device legislation. I will receive the results of that study early in 1970. . . ."

As yet, no legislation implementing the President's recommendations has been introduced.

* * *



MEDICAL NEWS

Ernst Schmidhofer, MD, is now associated with the Ohio Department of Mental Hygiene and Correction, Division of Psychiatric Criminology, Chillicothe, Ohio as Assistant Commissioner, Research and Program Development.

* * *

George N. Austin, MD, has moved his orthopaedic practice to Gottsche Rehabilitation Center, P. O. Box 790, Thermopolis, Wyoming 82443.

* * *

Charmian Elkes, MD, psychiatrist, announces the removal of her office to Columbia Hospital and Clinics, Columbia, Maryland 21043.

* * *

The offices of **Frank F. Schuster, MD,** and **Howard Moses, MD,** are now located at 819 Park Avenue, Baltimore, Maryland 21201.

* * *

Frederick P. Pokrass, MD, has been named Superintendent of Springfield State Hospital. Making the appointment was **James E. Carson, MD,** Commissioner of the Department of Mental Hygiene.

Dr. Pokrass joined the staff of Springfield State Hospital in 1965 as Director of Psychiatric Community Services, and also served for three years as the hospital's clinical director. He has been serving as acting superintendent of the hospital since January 1, 1969. Dr. Pokrass received his BS degree from Cornell University and his medical training at the University of Maryland School of Medicine.

* * *

The newly appointed director of the department of nursing service at the University of Maryland Hospital is **Jean T. MacVicar.** The announcement was made jointly by **George H. Yeager, MD,** director of the hospital, and **Marion I. Murphy, MD,** dean of the University of Maryland School of Nursing, where Mrs. MacVicar is chairman of the graduate program in administration of nursing—a position she will continue to hold.

This kind of joint appointment —the administration of current nursing practice and the education of future nursing administrators within the same hospital —is unique in the country, and should help to unify the two programs which have previously been inappropriately divided.

* * *

Sponsored by the **Regional Medical Program for Maryland, Sinai Hospital** of Baltimore operates a comprehensive and team outpatient program for the rehabilitation of stroke patients, including physical and occupational therapy, speech and hearing therapy, vocational evaluation and counseling in the areas of social and emotional adjustment. Referrals are requested.

Further information is available by writing to: Stroke Program, Department of Rehabilitation Medicine, Sinai Hospital, Belvedere at Greenspring, Baltimore, Maryland 21215, or by calling the Stroke Program Office (301) 367-7800, Extension 8801.

* * *

A new handbook, *Home Care Programs in Arthritis,* is now available from the Maryland chapter of **The Arthritis Foundation,** 12 West 25th Street, Baltimore, Maryland 21218. This handbook will be given to patients only with the approval of the attending physician.

* * *

J. Sydney King, of WBAL-TV, Baltimore, has been awarded first prize in the 13th Annual Russell L. Cecil Awards for excellence in broadcasting about arthritis. His 90-minute program, "Arthritis: Questions and Answers," broadcast January 26, 1968, won him $500 and an engraved medallion.

* * *

A. Edward Maumenee, MD, professor and director of the department of ophthalmology at The Johns Hopkins University School of Medicine, has been named president-elect of the American Academy of Ophthalmology and Otolaryngology, and will assume his post January 1, 1970. On January 1, 1971, he will become president of the Academy.

Dr. Maumence served as first vice-president of the organization in 1964, and the following year was elected to the Academy's Board of Councilors and served a four-year term. At present, Dr. Maumenee is also ophthalmologist-in-chief at The Johns Hopkins Hospital.

* * *

An organization has recently been formed which is interested in halting the population explosion. **Zero Population Growth, Inc.** is a nationwide, nonprofit, volunteer organization geared to achieving zero population growth in the United States by 1980 and in the world by 1990. **Dr. Paul R. Ehrlich,** the author of the book *The Population Bomb,* and a biologist at Stanford University, is currently president of the group.

* * *

Reversing the position it had held since 1963, the **Internal Revenue Service** recently ruled that professionals (doctors,

lawyers, etc) can now incorporate to gain tax benefits. Although it had charged that professionals were incorporating to gain favorable tax treatment on funds allocated to pensions, retirement, profit-sharing, etc, courts repeatedly sided with the taxpayers and more states overruled the decision and passed appropriate legislation. The nation's independent business owners, voting through the National Federation of Independent Business, gave support to a bill introduced by Representative Ancher Nelsen of Minnesota to require IRS to recognize professional incorporations under state laws. The Internal Revenue Service's new position makes such legislation now unnecessary.

* * *

Richard S. Ross, MD, Clayton Professor of Cardiovascular Disease at The Johns Hopkins University School of Medicine, and director of the cardiovascular division of the department of medicine, recently delivered two major lectures in Great Britain, in which he reviewed his research of the past ten years. On November 13, 1969, Dr. Ross gave the Sir Thomas Lewis Lecture before the British Cardiac Society, at the Royal College of Physicians in London. He then traveled to Scotland for the Bronte-Stewart Memorial Lecture on November 20, 1969, at the University of Glasgow.

Dr. Ross has developed techniques for measuring blood flow to the heart, and has been studying the pressures developed within the heart during attacks of angina pectoris, as well as the biochemical changes that occur within the heart when it does not receive sufficient oxygen. He has been consultant to the National Heart Institute since 1961, and was president of the Maryland Heart Association in 1968.

* * *

Emile R. Mohler, Jr., MD, has been appointed Chairman of the Department of Medicine and Director of the Medical Services Laboratory at St. Agnes Hospital in Baltimore. Prior to assuming his new post, Dr. Mohler had been chief of St. Agnes' section of hematology since 1968.

A native of Baltimore, Dr. Mohler graduated from Loyola College and received his MD degree from Georgetown University, Washington, D. C. He served an internship at University Hospital in Baltimore, and completed his residency at St. Agnes Hospital, his last year as Chief Resident of Medicine. He has been awarded two fellowships and is a member of several national medical societies.



Dr. Mohler

* * *

The Upjohn Company has taken legal action to prevent the Federal Food and Drug Administration from enforcing an order that would remove seven of the company's combination antibiotic products from the market. R. T. Parfet, Jr., president and general manager of the drug company, feels that the FDA is in error and that their actions are certainly unjustified. The case is being heard before the U. S. Court of Appeals in Cincinnati, Ohio, this month.

* * *

At the October 19, 1969 meeting of the **Schizophrenia Foundation of Greater Washington, Inc.** held in Bethesda, Maryland, **David Hawkins, MD,** gave a talk which presented facts compiled from almost 1400 cases studied in a four-year period. A copy of the tape recording of Dr. Hawkins' talk will soon be added to the chapter library and may be reserved for group use.

On November 20, 1969, **Albert A. Kurland, MD,** Assistant Commissioner for Research, Maryland Department of Mental Hygiene, and Director of the State of Maryland's Psychiatric Research Center, spoke before the Foundation on the topic "The Use of Psychotropic Drugs in Mental Health Research in Maryland State Hospitals."

* * *

The Senate Finance Committee has ruled that unrelated business income of tax exempt organizations is now taxable. Any income derived by a tax exempt organization which is not directly related to its tax exempt function would now be subject to taxation.

* * *

Share with Others—Give to
THE SALVATION ARMY



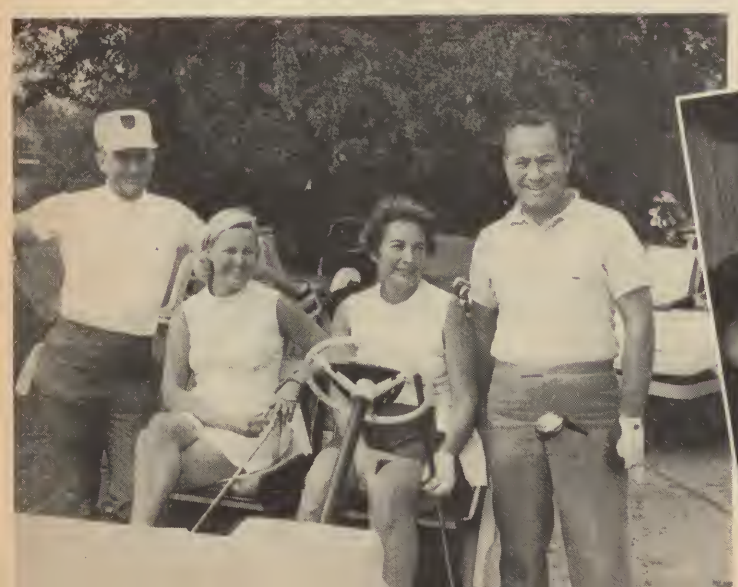




The Semiannual Meeting in Hershey in September appears to have been an out-and-out success. Witness (counter-clockwise) **the grins from the VIP table** (above)**: Dr. Elmer Linhardt, Mrs. Russell S. Fisher, Dr. DeWitt E. DeLawter, Dr. Fisher, Mrs. DeLawter, Dr. Wallace Sadowsky, Mrs. Linhardt and son, Bing. Even the small fry of the Chissell and Smoot clans enjoyed the festivities along with parents Dr. Roland Smoot, Dr. John Chissell and Mrs. Chissell.**

The frolicsome threesome at right are Barbara Laughlin, Mrs. Raymond Yow, and Faculty staff member, Mrs. Constance Galton (where there's fun there's Connie!). The golf course attracted Dr. and Mrs. William Dunsheath and Dr. and Mrs. William C. Ebeling. Then there was the knobby knees contest . . . won, of course, by Dr. Richard Bauer. Other identifiable contestants pictured are Dr. Sadowsky (with back? to camera), and Dr. Henry Laughlin. 1970's Semiannual, now in the works, sounds as though it's going to be even bigger and better.

Who sez the medical profession is stodgy?





The 1969 Med-Chi Semiannual Meeting in Retrospect

Hotel Hershey September 4, 5, 6

The Semiannual Meeting, under the chairmanship of DeWitt E. DeLawter, MD, was a complete success both socially and scientifically. Attendance at the scientific sessions and specialty society meetings was unusually good, and the panel discussion on drug abuse, sponsored by the Faculty, was attended by over 200 physicians and their wives.

In addition to the annual Friday evening banquet, the Woman's Auxiliary, under the direction of Mrs. Wallace H. Sadowsky, president, arranged a Fun Night. Mrs. Richard D. Bauer was mistress of ceremonies and cleverly introduced the entertainers.

One of the most ingenious acts was performed by Mrs. Elmer Linhardt and her daughter, Angie. Their tribute to "Our Men in Medicine" was musical and highly amusing. For the Welcome, Angie played "Hail! Hail! The Gang's all Here"; a general salute to our men in the field of medicine was "O Dear, What Can the Matter Be?"; surgeons rated "Mack the Knife"; pediatricians were greeted with "Ten Little Indians"; general practitioners were saluted with "Don't Fence Me In!"; gynecologists were heralded with "Keep Your Sunny Side Up"; obstetricians with "Mary Had a Little Lamb"; EENT's with "Look Down, Look Down, That Lonesome Road"; "I've Got You Under My Skin" was for the dermatologists; for the "heartbreakers", the cardiologists, Angie played "Heartaches"; urologists were saluted with "April Showers"; "Dem Bones" was aptly played for orthopedists; anesthesiologists were greeted with "I'm Forever Blowing Bubbles"; "Me and My Shadow" haunted the radiologists; proctologists with "There's a Long, Long Trail A-Winding"; pathologists listened to "Look for the Silver Lining"; and the "long-suffering psychiatrists" were saluted with "If You Knew Susie . . .". As a special salute to Dr. Russell S. Fisher, the whole assemblage joined in singing "For He's a Jolly Good Fellow", and then wound up the act with a salute to each other with "When the Saints Go Marching In."

Other features of Fun Night included the Washington County Auxiliary Warblers singing parodies; Mrs. Raymond Yow did a tap dance and led a Can-Can; Dr. Richard Bauer gave forth with some of his original recitations; and his daughters sang two lovely duets.

Another evening enjoyed by many members and their families was the "Monte Carlo Night" in the Game Room of the Hotel.

The first golf tournament held in connection with a Semiannual Meeting proved most successful with over 50 persons participating. First prize for low score went to Dr. William J. Peeples, Commissioner of Health for the State of Maryland.

The facilities and services at Hotel Hershey left nothing to be desired. The cooperation of the Hotel Staff was excellent.

Minutes

Semiannual Session, House of Delegates

(266th Meeting)

Medical and Chirurgical Faculty of the State of Maryland

Friday, September 5, 1969

Hershey Hotel, Hershey, Pa.

The 266th meeting, Semiannual Session, of the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland was called to order at 9:30 AM, Friday, September 5, 1969, at the Hershey Hotel, Hershey, Pa., the President and Secretary being present.

The following delegates (or alternates) were registered as being in attendance; an asterisk indicates an alternate delegate.

Doctors:

Robert G. Angle, Montgomery County; *Charles Bagley, III, Wicomico County; Timothy D. Baker, Baltimore city; John G. Ball, Council; James W. Banks, Washington County; Richard D. Bauer, Past President; M. McKendree Boyer, Past President; Henry A. Briele, Council; *D. Delmas Caples, Baltimore County; Douglas Gordon Carroll, Baltimore city; Katharine A. Chapman, Montgomery County; John T. Chissell, Council; John N. Classen, Baltimore city; Archie Robert Cohen, Washington County; Kenneth Cruze, Montgomery County; William B. Culwell, Carroll County; Worth B. Daniels, Jr., Baltimore city; Melvin B. Davis, Baltimore County; John B. DeHoff, Baltimore city; DeWitt E. DeLawter, Montgomery County; John M. Dennis, Council; J. Sheldon Eastland, Past President; Wm. Carl Ebeling, Council; Wolcott L. Etienne, Council; *Robert W. Farr, Kent County; James McC. Finney, Harford County; Vincent J. Fiocco, Carroll County; Russell S. Fisher, Council; Marvin Goldstein, Baltimore city; Paul F. Guerin, Council; William B. Hagan, Council; Louis E. Harmon, Baltimore city; Claude D. Hill, Baltimore city; Wm. A. Holbrook, Jr., Prince George's County; *Edward Hopf, Baltimore County; *John C. Hyle, Baltimore County; J. Parran Jarboe, Council; Frederick M. Johnson, Charles County; Ferd E. Kadan, Baltimore city; James R. Karns, Baltimore city; Seruch T. Kimble, Council; *John I. F. Knud-Hansen, Talbot County; *John M. Krager, Baltimore County; *Justinas Kudirka, Howard County; Henry P. Laughlin, Council; C. Rodney Layton, Queen Anne's County; Elmer G. Linhardt, State Board of Medical Examiners; Deonis M. Lupo, Baltimore city; *Francis C. Mayle, Jr., Montgomery County; Karl F. Mech, Council; B. Martin Middleton, Council; John E. Miller, Baltimore city; Donald W. Mintzer, Baltimore city; Marvin I. Mones, Council; *Howard T. Morse, Montgomery County; Frederick E. Musser, Prince George's County; Sidney Novenstein, Washington County; Chas. F. O'Donnell, Council; *J. Allan Offen, Montgomery County; Hilary T. O'Herlihy, Anne Arundel County; A. Austin Pearre, Past President; Wm. A. Pillsbury, Jr., Council; *Harold B. Plummer, Caroline County; J. Morris Reese, Council; Harry G. Reeves, Wicomico County; Thomas Reid, Frederick County; William F. Renner, Baltimore city; Philip L. Repetto, Jr., Prince George's County; Peter W. Rieckert, Dorchester County; Martin A. Robbins, Baltimore city; Raymond C. V. Robinson, Baltimore city; Donald J. Roop, Council; John F. Schaefer, Council; *J. Thomas Schnebly, Montgomery County; Arthur G. Siwinski, Council; R. Kennedy Skipton, Prince George's County; Roland T. Smoot, Baltimore city; Aaron C. Sollod, Baltimore city; Wm. G. Speed, III, Council; George R. Spence, Montgomery County; *Robert F. Spicer, Montgomery County; *William N. Thomas, Jr., Anne Arundel County; F. J. Townsend, Jr., Worcester County; Thos. E. Van Metre, Jr., Baltimore city; *Hugh W. Ward, Calvert County; Chas. H. Williams, Baltimore County; Charles E. Wright, Frederick County; Emerson C. Walden, Baltimore city; *N. Louise Young, Baltimore city; Raymond M. Yow, Council.

Present also were staff personnel.

Invocation

Donald W. Mintzer, MD, delivered the invocation.

Announcements

The President made certain announcements with regard to the conduct of business at the session.

Introduction of New Members

The President introduced the following new members of the House of Delegates:

Richard Y. Dalrymple, MD, Westminster (Council)

Marvin I. Mones, MD, Silver Spring, First Vice-President (Council)

Samuel Morrison, MD, Baltimore, Second Vice-President (Council)

Guy M. Reeser, Jr., MD, St. Michaels, Third Vice-President (Council)

Robert J. Thomas, MD, Frederick (Council)

Minutes

The minutes of the House of Delegates meetings of April 9, 1969 and April 11, 1969, having been distributed to the members and having been approved by the Executive Committee, were presented to the House for information.

Emeritus Membership

On motion of the Council Chairman, the following members who had received the recommendation of their respective societies and The Council, were elected to Emeritus Membership in the Faculty:

Baltimore City Medical Society:

Jerome J. Blumberg, MD
Warfield M. Firor, MD
R. Carmichael Tilghman, MD

all of Baltimore city

Honorary Membership

On motion of the Council Chairman, upon the Executive Committee's recommendations, the following individual was unanimously elected to Honorary Membership in the Faculty:

W. B. Kouwenhoven, Dr. Ingr., MD (Hon)

Adoption of Standing Rule

On motion of the Council Chairman, in accordance with previous notice, and on recommendation of the Council, the following Rule 4 of the Standing Rules was adopted by majority vote:

> A Committee chairman or the reporting member of a committee who is not a member of the House of Delegates shall have the privilege of making motions and speaking in debate in connection with the report of such committee. Others who are not members of the House of Delegates may, by a three-fourths vote, be extended the privilege of making a verbal report to the House for a time not to exceed five minutes. They may, by majority vote, be allowed to revise and extend their report for publication in the Transactions issue of the *Maryland State Medical Journal.*

Presentation of Viet Nam Plaque

The presentation of a plaque to **Wayne Foster, MD,** for voluntary service under the AMA Physician Volunteers for Service in Viet Nam was deferred because of his return to Viet Nam for continued service there.

Resolution Honoring John M. T. Finney, Jr., MD 1894-1969

Henry A. Briele, MD, President-elect, offered the following resolution honoring **John M. T. Finney, Jr., MD,** which was adopted unanimously by the House:

> Whereas, One of medicine's most illustrious and beloved persons was taken from this world on April 15, 1969; and,
>
> Whereas, **John M. T. Finney, Jr., MD,** is one of a long line of distinguished physicians known throughout Maryland, the United States and the entire world; and
>
> Whereas, To quote from an Editorial appearing in the Sunpapers shortly after his death:
>
> > "The lustre of his career is reflected in the lasting gratitude of the hundreds of patients who could never forget his warmth and understanding as well as his skill.";
>
> and,
>
> Whereas, He served with distinction in various organizations of physicians such as President of the Baltimore City Medical Society, Vice-president of the Southern Surgical Association, founder of the Eastern Surgical Society, and in many other medical and civic capacities; and
>
> Whereas, While he retired from active practice in 1953, he continued to evince an interest in all things medical; and
>
> Whereas, The characteristics, sympathies and compassion he showed to all with whom he came in contact were always self-evident and will always be remembered; be it
>
> *Resolved,* That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland at its meeting held on September 5, 1969, take due notice of the death of **John M. T. Finney, Jr., MD;** and be it
>
> *Resolved,* That this resolution be spread upon the minutes of that meeting, with a copy to be sent to his nearest relatives together with this expression of regret on his death.

Resolution Honoring Bernard O. Thomas, Sr., MD 1882-1969

Dr. Briele presented the following resolution honoring **Bernard O. Thomas, Sr., MD,** which was adopted unanimously by the House and reads as follows:

> Whereas, **Bernard O. Thomas, Sr., MD,** was known as the dean of physicians in Frederick County; and
>
> Whereas, His death on April 15, 1969, creates a great void in the community and is a great loss to the medical profession; and
>
> Whereas, His unselfish devotion to the welfare of the people and the community he served was without peer; and
>
> Whereas, Words in themselves fail to express the high regard and esteem in which he is held by the profession in Maryland; and
>
> Whereas, Whatever is said can only begin to state the feelings of those persons who knew him and were in contact with him; be it
>
> *Resolved,* That the House of Delegates of the Medical and Chirurgical Faculty of the State of Maryland, on September 5, 1969, expresses itself as being deeply bereaved at the loss of **Bernard O. Thomas, Sr., MD;** and be it
>
> *Resolved,* That this expression of its sorrow and regret be spread upon the minutes of that meeting and a copy of this resolution be sent to the nearest relatives.

Treasurer's Report

Karl F. Mech, MD, Treasurer, presented the Auditor's Statement for the year ended 1968, and moved adoption of the certification statement that appears on this report. The statement was unanimously adopted.

Bylaws Committee Report

Charles F. O'Donnell, MD, Chairman of the Bylaws Committee, on its behalf, reported back to the House a substitute for Article IV, Section 3, which had been recommended at the Annual Meeting, April 9, 1969, and recommended rejection of the following amendment which was pending at the time of recommitment:

Pending Bylaws Amendment Not Adopted

A component society in the central and south central districts shall be entitled to be represented on the Council as nearly as may be possible by one Councilor for each 200 active and Forty-year members in good standing of such component society on December 31 of each year.

The foregoing amendment to the Bylaw amendment was rejected and Dr. O'Donnell moved adoption of certain amendments which, after debate, were adopted and the Bylaw amendment, as amended, was then adopted by more than the required two-thirds vote, as follows:

Substitute for Article IV, Section 3, the following new section which reads as follows:

Section 3. One third of the COUNCILORS provided below shall be elected annually by the House of Delegates from among the active and Forty-year members of component societies comprising the following districts:

(a) Western District: Allegany, Garrett, Carroll, Frederick and Washington Counties
(b) Eastern District: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester Counties
(c) Central District: Baltimore city, Baltimore and Harford Counties
(d) Southern District: Anne Arundel, Calvert, Charles, Howard and St. Mary's Counties
(e) South Central District: Montgomery and Prince George's Counties

Representation shall be on the basis of one Councilor from each district, plus one additional councilor for each 200 active and Forty-year, or major fraction thereof, members in good standing on the preceding December 31 each year.

Dr. O'Donnell on behalf of the Bylaws Committee moved adoption of the following Bylaw amendments all of which were enacted by the necessary two-thirds vote:

Amend Article IV, Section 1, by striking out the figures "22"

Amend Article XI, Section 11, by inserting the words, "and formulate guidelines" after the word "complaints."

Amend Article XI, Section 14, by adding an additional sentence which reads as follows:

"The tenure of office for this Committee shall be for one year and shall commence at a time that is mutually agreeable with the Maryland State Bar Association, so as to ensure that individual members shall serve conjointly with their respective counterpart members."

Amend Article XI, Section 15, by striking out the entire section.

Amend Article XI, Section 17, by substituting a proposed new section which reads as follows:

Section 17. *AN OCCUPATIONAL AND ENVIRONMENTAL HEALTH COMMITTEE* of at least five members shall study and report as it deems advisable upon occupational and environmental health matters. It shall consider such subjects as occupational health problems in industry; consumer protection matters such as food, drugs, etc.; hazardous substances, such as poisons, toys, devices, etc.; the quality of the health environment such as water and air pollution and land use, etc.; as well as traffic safety, such as warning devices, highway signs, automobile construction, accident evacuation, first aid training, etc.

Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the president.

The question as to what person or committee would arrange memorials or tributes to members or deceased members was referred to the Bylaws Committee for whatever action was deemed necessary.

(See page 105 for the complete report)

Information Committee Reports

The following reports were distributed in writing for the information of the meeting and an opportunity was afforded at this time to raise any questions:

Board of Medical Examiners—Elmer G. Linhardt, MD, *Secretary*

Medical Economics Committee—W. Kenneth Mansfield, MD, *Chairman*

Legislative Committee—B. Martin Middleton, MD, *Chairman*

Liaison Committee—W. Donald Mintzer, MD, *Chairman*

Mediation Committee—Lewis P. Gundry, MD, *Chairman*

Medicolegal Committee—Robert W. Johnson, III, MD, *Chairman*

Occupational Health Committee—Harold P. Biehl, MD, *Chairman*

Professional Medical Services Committee—George H. Greenstein, MD, *Chairman*

Representatives on the Medical Advisory Committee of the Red Cross Blood Bank Program

(These reports appeared in the June Journal)

Faculty's Delegates to the American Medical Association House of Delegates

Robert vL. Campbell, MD
J. Sheldon Eastland, MD
Russell S. Fisher, MD

(See page 108 for report)

Announcements

Various announcements were made for information of the House of Delegates.

Adjournment

The President, by general consent, declared the House adjourned *sine die,* at 10:30 AM.

WILLIAM A. PILLSBURY, MD, *SECRETARY*



Let's be specific about Campbell's Soups... and *reducing diets*



There are more than 30 million people in America who are overweight. During the next year, you probably will see more than 1,000 of them in your own practice.

One good way to help these patients is to give them a reducing diet based on ordinary eating patterns.

Campbell has prepared a sensible plan for weight control based on ordinary eating patterns. The plan consists of a patient instruction booklet and a set of menus which provide approximately 1,400 calories daily. The menus are balanced to provide the minimum daily requirements of nutrients.



To obtain a supply for your office write to:
Campbell Soup Company, Box 265, Camden, N. J. 08101

in acute and chronic diarrheas

LOMOTIL® SAVES...

TABLETS/LIQUID

Each tablet and each 5 cc. of liquid contain:
diphenoxylate hydrochloride .....2.5 mg.
(Warning: May be habit forming)
atropine sulfate, 0.025 mg. (1/2,400 grain)

body fluids... electrolytes... patients from exhaustion

Lomotil acts promptly and directly to lower the excessive intestinal motility of diarrhea. This therapeutic restraint on the overactive bowel allows a normal or more nearly normal reabsorption of water and electrolytes.

The proficiency of Lomotil in conserving body fluids and electrolytes often saves patients from the exhaustion that accompanies prolonged diarrhea.

Lomotil acts to control the intestinal mechanisms of diarrhea; therefore, it is highly useful in controlling diarrhea associated with:

gastroenteritis · acute infections · functional hypermotili
irritable bowel · ileostomy · drug-induced diarrhea

Warnings: Lomotil should be used with caution in patients taking barbiturates and with caution, if not contraindicated, in patients with cirrhosis, advanced liver disease or impaired liver function.

Precautions: Lomotil is a Federally exempt narcotic with theoretically possible addictive potential at high dosage; this is not ordinarily a clinical problem. Use Lomotil with considerable caution in patients receiving addicting drugs. Recommended dosages should not be exceeded, and medication should be kept out of reach of children. Should accidental overdosage occur, signs may include severe respiratory depression, flushing, lethargy or coma, hypotonic reflexes, nystagmus, pinpoint pupils, tachycardia; continuous observation is necessary. The subtherapeutic amount of atropine sulfate is added to discourage deliberate overdosage.

Adverse Reactions: Side effects reported with Lomotil therapy include nausea, sedation, dizziness, vomiting, pruritus, restlessness, abdominal discomfort, headache, angioneurotic edema, giant urticaria, lethargy, anorexia, numbness of the extremities, atropine effects, swelling of the gums, euphoria, depression and malaise. Respiratory depression and coma may occur with overdosage.

Dosage: The recommended initial daily dosages, given in divided doses until diarrhea is controlled, are as follows:

Children:	*Total Daily Dosage*
3-6 mo.	½ tsp.* t.i.d. (3 mg.)
6-12 mo.	½ tsp. q.i.d. (4 mg.)
1-2 yr.	½ tsp. 5 times daily (5 mg.)
2-5 yr.	1 tsp. t.i.d. (6 mg.)
5-8 yr.	1 tsp. q.i.d. (8 mg.)
8-12 yr.	1 tsp. 5 times daily (10 mg.)
Adults:	2 tsp. 5 times daily (20 mg.) or 2 tablets q.i.d.

*Based on 4 cc. per teaspoonful.

Maintenance dosage may be as low as one-fourth the initial daily dosage.

G. D. **SEARLE** & CO.
Research in the Service of Me
951



this ulcer did not heal...until its surface was cleared of dead tissue and debris



FIRST APPLICATION
ELASE Ointment is applied to a deep ulceration of a finger.

EIGHTEEN DAYS LATER
Healing has progressed rapidly without interruption or interference from any accumulated purulence or necrotic tissue. Greatly reduced size of lesion and minimal scar tissue indicate quality and vigor of healing which is almost complete.



to aid in debridement to facilitate healing in chronic cutaneous ulcers...

Elase® Ointment

(fibrinolysin and desoxyribonuclease, combined, [bovine] ointment)

PARKE-DAVIS

By helping to remove dead tissue and debris from the ulcer's surface, ELASE Ointment creates a better environment for the elimination of infection, for healthy granulation...*for healing.* Its lytic enzymes effectively break down DNA in dead leukocytes and other debris...the fibrin in blood clots, serum, and purulent exudates...and the denatured proteins in necrotic tissue. Protein elements of *living* tissue are relatively unaffected. ELASE Ointment is indicated in stasis ulcers and in other infected or inflamed ulcers caused by circulatory disturbances. In cases requiring skin grafting, it is used preoperatively for debridement. For ambulatory patients debridement with ELASE Ointment is a convenient therapy and a regimen likely to be followed. *Precautions:* Observe usual precautions against allergic reactions, particularly in persons with a history of sensitivity to materials of bovine origin or to mercury compounds. *Adverse Reactions:* Side effects attributable to the enzymes have not been a problem at the dose and for the indications recommended. *Discussion:* Successful use of enzymatic debridement depends on several factors: (1) dense, dry eschar, if present, should be removed surgically before enzymatic debridement is attempted; (2) the enzyme must be in constant contact with the substrate; (3) accumulated necrotic debris must be periodically removed; (4) the enzyme must be replenished at least once daily; and (5) secondary closure or skin grafting must be employed as soon as possible after optimal debridement has been attained. It is further essential that wound-dressing techniques be performed carefully under aseptic conditions and that appropriate systemically acting antibiotics be administered concomitantly if, in the opinion of the physician, they are indicated. *Available:* ELASE Ointment is supplied in 30-Gm. tubes containing 30 units (Loomis) of fibrinolysin and 20,000 units of desoxyribonuclease with 0.12 mg. thimerosal (mercury derivative); and in 10-Gm. tubes containing 10 units of fibrinolysin and 6,666 units of desoxyribonuclease with 0.04 mg. thimerosal. ELASE Ointment has a special base of liquid petrolatum and polyethylene; contains sodium chloride and sucrose used during manufacture; is stable at room temperature through the expiration date stated on the package.

Parke, Davis & Company, Detroit, Michigan 48232

PARKE-DAVIS

48168

3 Ways
to express yourself:
Professionally



Continental
MARK III



Lincoln Continental
MERCURY
Marquis





LET US ASSIST YOU IN YOUR CHOICE OF CARS
AND WHETHER TO LEASE OR OWN.

King Size courtesy, service, savings, plus

1. Direct "hot" line to Service Manager.
2. No waiting in Service lane.
3. Free Continental to drive while yours is in the shop.

FREE GIFT for taking a test drive. Come in and inspect our beautiful new facilities.

MONARCH

COUGAR • MERCURY • MONTEGO • CONTINENTAL

5525 BALTIMORE NATIONAL PIKE

Route 40 1 Mile East of Beltway Exit 15 East
744-4300 • Open 9-10 • Sat. 9-9 • CLOSED SUNDAY

For elderly patients in need of a mild tranquilizer consider **Tybatran**®

brand of tybamate

(When you consult the Prescribing Information you may agree it makes good sense)



PRESCRIBING INFORMATION

Indications: Tybatran (tybamate) has afforded symptomatic improvement in a variety of psychoneurotic disorders, especially in the treatment of the anxiety and tension components of psychoneuroses. Anxiety states manifested somatically have responded to Tybatran (tybamate).

Tybatran (tybamate) has been useful in the control of agitation in the aged and in the alleviation of some of the adverse emotional accompaniments of senility.

Tybatran (tybamate) has been used with benefit in the treatment of depressive symptoms associated with anxiety and other symptoms of psychoneuroses. However, it is not indicated for primary treatment of depressive states. It is not an antipsychotic agent, although it has been used as adjunctive therapy in some psychotic patients.

Dosage: One 350 mg. capsule, 3 times daily and two at bedtime is suggested as the adult starting dose. Adjust to suit individual requirements. Daily doses above 3000 mg. are not recommended.

Contraindications: Known hypersensitivity to tybamate. Since no studies have been done with this drug in human pregnancy, it should not be used in pregnancy unless the potential benefit outweighs the risk.

Warnings: Administer cautiously to patients receiving phenothiazines or other CNS depressants or having history of convulsive seizures (See Adverse Reactions). Consider possibility of additive actions with alcohol or other psychotropic agents, particularly phenothiazines or MAO inhibitors.

Precautions: Avoid abrupt withdrawal after prolonged use, although withdrawal symptoms have not been reported to date. Exercise caution in addiction-prone individuals. If symptoms of hypersensitivity occur, discontinue at once and initiate appropriate symptomatic treatment. Avoid activities requiring optimal mental alertness if drowsiness or vertigo are present. As with any new drug, use cautiously in patients with history of drug allergies, blood dyscrasias, and hepatic or renal disease; periodic measurements of hepatic, hematopoietic and renal function should accompany prolonged and/or high doses.

Adverse Reactions: Most frequent reactions, rarely requiring discontinuation of tybamate, include drowsiness, dizziness, nausea, insomnia, and euphoria. There have been a few reports of skin rash, urticaria, and pruritus. Rare side effects include hyperactivity, fidgetiness, flushing, and tachycardia, suggesting excessive stimulation; also ataxia, unsteadiness, confusion, feeling of unreality, "panic reaction," fatigue, headache, paresthesias, vertigo, gastrointestinal disturbances, glossitis, and dry mouth. Grand mal or petit mal seizures have been reported in a few hospitalized psychotic patients receiving tybamate (up to 6000 mg. daily) together with phenothiazines and other psychotropic agents, but not with tybamate alone. Consider the possibility of rare, serious adverse reactions such as may occur with the related drug, meprobamate. If excessive amounts are ingested, gastric lavage and symptomatic therapy, including central stimulants as necessary, are recommended. Before prescribing, consult package circular.

Supply: Tybatran (tybamate) is available in green, sealed capsules of three strengths: 350 mg., 250 mg., and 125 mg. Each strength is supplied in bottles of 100 and 500.

A. H. Robins Company, Richmond, Va. 23220

A·H·ROBINS

Senate Bill 404: A Working Solution to the State's Health Problems

Senate Bill 404, adopted by the 1969 General Assembly and signed into law by the Governor, became effective July 1, 1969. At that time, the newly created post of Secretary of Health and Mental Hygiene came into existence.

In 1960, the Committee of Medical Care of the State Planning Commission recommended that a "State Board of Health and Hospitals" be established to replace the former separate Boards of Health and Mental Hygiene. Under the new proposal, such a new Board would have had a Chief Executive Officer (probably a qualified physician) responsible for establishing policy and seeing that it was executed. Unfortunately, legislation drafted to create such a board was defeated, and the Commissioner of Health and Commissioner of Mental Hygiene retained their positions. Problems within the two policy-making bodies grew, and Maryland's health and mental hygiene problems merely increased in number and scope.

Recognizing the rapidly growing and acute problem, the State Legislature recently chose to reorganize the entire complex into one Department, headed by a Secretary who would be responsible to the Governor. Thus, after nine years of drifting, we finally have a properly and adequately organized Department of Health and Mental Hygiene.

The new Secretary and his assistants face a formidable task in reversing the course of Maryland's health programs. To date, the Secretary has exercised wisdom and skill in handling the numerous problems that were suddenly thrust upon him. He and his staff have made themselves readily available and have moved decisively and promptly in responding to requests for long-delayed answers on policy matters. We see no reason why this expertise cannot continue to be directed toward health programs for Maryland that will adequately serve its expanding population. We wish the new staff well and offer our assistance in whatever way we can to accomplish this objective.

John Sargeant

Electrodes for Cardiac Monitoring in the Coronary Care Unit:

Description of the Disposable Daisy Electrode

JOHN J. CURRY, MD
Director, Coronary Care Unit
Holy Cross Hospital
Silver Spring

Cardiac monitoring experience in the Holy Cross Hospital Coronary Care Unit, over a three-year period, is reviewed in respect to the various types of monitoring electrodes employed. The disposable Daisy electrode was used over a two-year period and after several improvements it was highly satisfactory. False alarms occurred not more than six times a week in a six-bed unit. The availability of this electrode led to great relaxation of former restrictions on the use of a bed-side commode and patient involvement in such self-care activities as partial bathing, feeding, reading, and the use of an electric razor. Obviously, the application of some of these features would improve the other disposable electrodes offered for monitoring purposes.

The rapid development of Coronary Care Units in the past several years has stimulated renewed interest in cardiac monitoring devices. Heart rate and rhythm disturbances may be recorded by ballistocardiography, impedance plethysmography, thermography, and peripheral pulse wave measurements. The majority of monitoring systems scan the RR or SS interval of the electrocardiogram for determination of rate and require a clear signal of good amplitude.

The monitoring problem differs from that of the clinical recording of the electrocardiogram in that motion and artifact must be expected and compensated for in a variety of ways. Skeletal muscle contractions, ambient electrical impulses, and electrode motion and battery action inevitably occur during continuous recording of the electrocardiogram of patients in the Coronary Care Unit. Indeed, the ability to monitor patients during the use of the bedside commode, and in self-care activities such as partial bathing, self-feeding, reading, and using an electric razor has led to great relaxation of restrictions in the bed care of such individuals. Extensive psychological studies in our unit over the past two years have led us to believe that these activities are extremely important to the patient. They do much to overcome the feeling of helplessness, depression and dependence that develops in so many patients with acute myocardial infarcts.

False alarms, resulting from poor, misplaced or detached electrodes, or from ambient electrical discharges, or skeletal muscle contractions, have plagued all Coronary Care Units. It is essential to overcome this problem because observation has shown that the personnel in many hospitals turn off the alarm systems and operate solely by visual scan of the oscilloscope. This practice results in delay in arrhythmia detection and treatment.

This report concerns our monitoring experience during a three-year period in the Coronary Care Unit at Holy Cross Hospital. During this time we tried, and abandoned, several types of electrodes ending with the development and improvement of the disposable Daisy electrode.

In any discussion of the prevention of false alarms it may be advantageous to consider first the recording and display apparatus itself and then the electrodes. In our instruments, not only is the amplitude of the R or S wave detected, but also the angle of inscription of the wave. Many skeletal muscle potentials are thus eliminated. More patient activity may then be allowed.

A lead fail system enables the detection of an improperly secured electrode, or one that becomes detached. When such an event occurs the impedance under the electrode undergoes a sharp rise and the lead fail alarm, an amber light, shows in place of an arrhythmia alarm, a red light. In our particular system a rise of over twelve thousand ohms in the recording electrode, or eight thousand ohms in the ground electrode, will register a lead fail alarm. The faulty electrode may be tested by pushing it against the skin with one finger. This will decrease the impedance and the lead fail signal should disappear. If the electrode is not securely fastened slight tugging on it will cause a lead fail signal to appear. Dry electrode paste will likewise cause a lead fail signal.

Alternating current is eliminated by common mode rejection. This is a standard method for dealing with this problem and is especially important in our system since we employ an unshielded electrode lead wire to allow more pliability and reduce expense.

Other systems have attempted to reduce false alarms by introducing a delay of several seconds or more between the advent of abnormal signals and registration of the alarm. This practice should be discouraged since it adds to delay in treatment; our delay period is only a few milliseconds.

Various hybrid computers are also available and these may be programmed to reduce false alarms. At the present time, the cost of this equipment is prohibitive.

The electrode problem presents many facets. The better grade of electrode with silver chloride on a silver surface develops less potential on interaction with skin, electrolytes, and electrode paste. Cost then precludes disposing of them, and time-consuming care and cleaning are essential. Surface abrasions, corrosion or placques of electrode jelly result in diminished efficiency. The size of the electrode must be large enough to give a good signal, but not so large as to make firm, even application to the skin a problem. Initially, we tried several types of flat conventional electrodes, but all were subject to motion and it was impossible to keep the electrode jelly moist.

Subcutaneous needles, electroencephalographic recording pins and stainless steel surgical sutures of varying sizes were also investigated. The pins were equally as effective as the needles and much less painful to insert subcutaneously due to their smaller size. It was noted that they could be inserted through and through intradermally with no pain whatsoever and yet a good signal could be obtained. The needles, pins, and stainless steel surgical sutures could be left in place for up to seven days with little reaction except for a slight redness at the injection sites. The application of antibiotic ointments did not prevent this reaction. However, we found it impossible to fix these devices in any way to prevent motion and the resultant false alarms. Patients also complained of painful tugging on the electrodes during motion.

The concept of a disposable electrode, with sav-

ings in time and cost, appealed to us and we began to use the Daisy electrode. Gradual improvements were made in the electrode over a two-year period and many types of material were tried and discarded. False alarms became more infrequent, and at the present time we have fewer than six false alarms a week in a six-bed coronary care unit.

Several aspects of monitoring electrodes should be considered: the electrode structure, location, manner of attachment to the skin, preparation of the skin, the electrode jelly employed and the room temperature and humidity.

The Daisy is a low cost, disposable, silver-plated stainless steel electrode. The ventral surface was originally covered with polyurethane to afford a spacer to keep the electrode in even contact with the skin. This caused the paste to dry out quickly and false alarms developed. It is now covered with pure gum-rubber with perforations to allow electrode jelly application. The sulfides of the rubber do interact with the electrode metals with the resultant increase in impedance, but this is a tolerable condition (Fig. 1).



Figure 1. Ventral surface of electrode showing gum-rubber spacer with removable protective covering over micropore attachment and unshielded connecting cable with push-on terminal.

The dorsal surface required numerous changes. Various methods of inserting or soldering the lead wire to the electrode were employed. If this junction was not sufficiently strong, fragmentation of wire threads would occur and result in false alarms. This difficulty was overcome by weld-brazing the tip of the wire to the electrode disk. The silver supplies material for brazing (Fig. 2).



Figure 2. Dorsal surface of electrode revealing weld-brazing of cable to electrode to prevent fragmentation of wire.

The connecting electrode wire itself represented a compromise with cost and performance. It is unshielded and hence may pick up alternating current interference. However, as pointed out earlier, this interference can be dominated in the recording apparatus. The wire is lightweight and pliable. Initially, an alligator clamp served for attachment to the patient cable. This shredded the wire filaments and gave rise to false alarms. A standard push-on terminal is now employed.

The electrodes are attached to the skin over the chest wall in areas where the skeletal muscle structure is not well developed. An exploring electrode may be used to locate a position giving a good signal and avoids the need to waste electrodes by repositioning them. We like to obtain a well inscribed P wave as well as a tall R or S wave in order to differentiate atrial as well as ventricular arrhythmias. The right side monitor electrode is positioned on the manubrium or upper sternum. The left side electrode generally is located on the left anterior axillary line over the eighth or ninth rib. The ground electrode is in a similar position except that it is on the right (Fig. 3). If the left side monitor electrode gives a better signal elsewhere, such as over the posterior chest, then this site is

employed. External pacing electrodes are not preplaced any longer since we rely almost entirely on the transvenous electrode catheter for treatment of heart block. In an emergency, subcutaneous needles make good external pacing electrodes. The monitoring electrodes should not be placed over angular bony prominences since close attachment to the skin cannot be made in such areas.

Careful preparation of the skin is essential. If body hair is longer than one sixteenth of an inch, a square inch area should be shaved for each electrode site. A gauze pad saturated with alcohol or acetone is rubbed over the area to remove oils and dry the skin. Since acetone dries more quickly it is preferred.

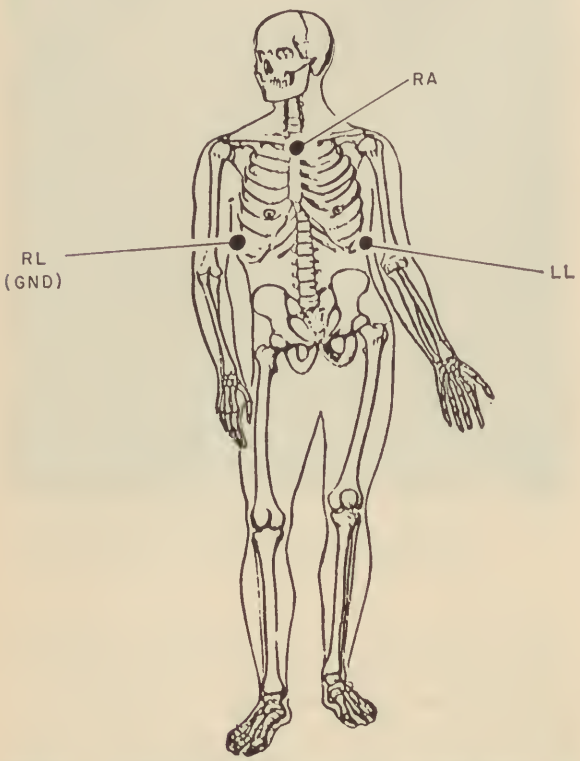


Figure 3. Electrode site locations recommended for monitoring.

The protective paper over the adhering surface of the micropore should be removed carefully to avoid contact with the surface. Four-tenths cubic centimeter of Cambridge electrode paste is applied to the disc with a syringe. Cambridge paste is employed because of a higher salinity. Excessive amounts of paste are avoided because contamination of the micropore leads to premature detachment of the electrode. Gentle pressure with the finger assures firm attachment of the electrode to the skin and prevents wrinkles. Gentle massaging of the applied electrode aids conduction.

Micropore represents a considerable improvement over adhesive or cellophane tape. It permits the passage of perspiration through its surface and hence promotes a longer and firmer attachment of the electrode. It is non-allergenic and permits bathing the area without fear of electrode dislodgment. The time required for electrode placement is short when careful attention is given to details. Great variation in cutaneous reaction is seen, especially in elderly patients with dry skin or light complected individuals. The electrodes may be left in place from one to seven days. The average length of time is three days.

Although our hospital is air-conditioned, we have not found this satisfactory in the Coronary Care Unit despite the installation of additional ducts. We would advise a separate air-conditioning system for the Unit. Excessive sweating does occasionally produce problems even with the micropore attachment. Much of this may be eliminated, however, with proper initial application of the electrode.

Supported in part by Contract No. PH 108-65-11 with the U.S. Public Health Service, Dept. of Health, Education and Welfare and Project Grant No. 09220-1, U.S. Public Health Service, Dept. of Health, Education and Welfare.

Daisy electrodes were kindly furnished by The General Electric Company through the courtesy of Keith C. Cormia.

Central venous pressure monitoring (CVP) has become a routine procedure on the wards of most hospitals. Its simplicity and reliability recommend its use in a variety of clinical situations.

Clinical Uses of Central Venous Pressure

NEIL A. ROBINSON, MD
Department of Surgery
Maryland General Hospital

Background

The current usage of CVP monitoring is basically derived from Starling's Law. He emphasized that venous pressure, especially right atrial, was a reliable index of cardiac competence. For as long as cardiac competence is present, right atrial pressures will stay within a narrow range; and as soon as myocardial fibers are overstretched and presystolic ventricular volume exceeds the capacity of the ventricular chamber, right atrial pressure will rise.[1]

Three useful corollaries for clinical application may be obtained from this hypothesis. First, when cardiac action is stable and there is no pronounced alteration of the vascular bed, blood volume and CVP will be *directly* related to each other.[2, 3] Next, when blood volume and the vascular bed are stable, cardiac competence and CVP will be *inversely* related.[1, 5-7] Finally, CVP may be unchanged, or may fall with a decrease in the tone of the vascular bed; and with an increase in the tone of the vascular bed, a rise may occur in the CVP in the incompetent heart and a transient rise may occur in the normal heart.[6]

Measurement

Measurement of the CVP requires the establishment of continuity between a simple measuring device and the *central* venous system. The latter is emphasized since measurements taken from peripheral veins are subject to errors arising from kinking of the vessels passing into the chest, as well as the pressure differential of the chest. In addition, peripheral venous constriction and venous valves interfere with the direct transmission of the right atrial pressure to the venous catheter.[4]

The literature is replete with numerous techniques for establishing continuity with the central venous system.[4, 5, 8, 9] These include cutdowns or percutaneous approaches to the jugular, subclavian, cephalic, saphenous, and femoral veins. The percutaneous route is preferable for its ease of entry, flexibility of management, and negligible infection rate. The saphenous and cephalic veins, because of their size and location, are not readily applicable to the percutaneous route. However, this approach is readily adaptable to the jugular, subclavian, and femoral veins. The femoral vein should be avoided when possible because of the incidence of phlebitis, phlebothrombosis, sepsis, pulmonary embolism and occasional mortality.[10] The femoral vein should be kept in mind when other veins are not available; for central venous pressure measurement in this area is identical to that of the superior caval system, except in the face of marked abdominal distention, when it may be falsely elevated. The percutaneous approach to the subclavian vein after Wilson [4] has been used exclusively by the author in over 200 patients with no morbidity.

Interpretation

After establishing continuity with the central venous system, a zero point is marked on the side of the supine patient ten centimeters from his back. This represents the level of the right atrium in the adult.[11] In children, one half of the anterior-posterior diameter of the chest is the correct zero point. A corresponding point is marked on the adjacent intravenous pole as the base line for subsequent measurements. With the use of a three-way stopcock, flow can be alternated from infusion to measurement as needed. All measurements must be made with the patient completely supine. The fluid in the manometer column should fluctuate with respiration to demonstrate an unobstructed connection to the central venous system.

The normal CVP in man ranges from three to eight centimeters of water. Isolated readings compared to this range serve as diagnostic indicators for the initiation of treatment. However, it is the trend

of the CVP, rather than any individual reading, which is significant in determining the patient's response.

Indications for Monitoring

The most important use of CVP monitoring is in the treatment of circulatory failure regardless of etiology. For here a working diagnosis can be made rapidly from the initial measurement of the CVP. We know from the corollaries outlined above that if the initial reading is low (0-5cm of water) the previously untreated patient is most likely to be hypovolemic. In any event, fluid therapy can be begun vigorously, and continued safely, until either a satisfactory improvement in the patient's condition has occurred or the CVP has risen to high levels (15cm of water or more). In the event the initial reading is in a normal range, fluid therapy may still be initiated with the same plan. However, if the initial reading is high (15cm of water or greater) the patient is most likely not hypovolemic. In any case, improvement of the cardiac status must be undertaken prior to vigorous fluid replacement.

Multiple causes of circulatory failure are sometimes evident. For example, circulatory failure may occur in the elderly patient who has a massive gastrointestinal hemorrhage, and a secondary coronary thrombosis. In this situation, central venous pressure monitoring will be of singular value in determining the amount and rate of transfusion, and the presence of cardiac failure. An elevated CVP in the presence of marked hemorrhage indicates there has been concomitant cardiac failure. This failure, *unrecognized*, would progress to pulmonary edema while the patient is being transfused; but with appropriate CVP monitoring the fine line between pulmonary edema and adequate tissue perfusion can be followed. In this hypothetical situation the absolute blood volume was not determined by the CVP, but more importantly, the patient's cardiac competence relative to *that* blood volume was indicated.

The use of CVP monitoring in the treatment of patients with circulatory failure is even more significant when we realize that they frequently are previously unknown to the treating physician. Assumptions concerning the cardiopulmonary status of these patients, regardless of age, cannot be made. Even the young can be overtransfused when the blood lost prior to treatment cannot be estimated, and conversely, the elderly patient may be undertreated with the result of a prolonged period of inadequate tissue perfusion.

The treatment of extensively burned patients should include CVP monitoring. Frequently there is not a readily available area for blood pressure measurement, and often no non-burned area for the introduction of a venous catheter. Usually the subclavian areas are unburned providing an aseptic intravenous route as well as an avenue to the central venous system. CVP monitoring is essential in burned patients for several reasons: It is an important adjunct to the serial hematocrit and urinary output for fluid replacement, especially in the presence of myocardial disease; it is of critical value in differentiating pulmonary edema from the wheezes and rales associated with respiratory burns; and in addition, if acute tubular necrosis supervenes, and urinary output can no longer be used for a guide to volume replacement, CVP monitoring is of singular importance.

Conditions in which widespread alterations in blood volume can be anticipated and poorly tolerated demand CVP monitoring, specifically in extensive cancer surgery or vascular surgery in elderly patients with brittle cardiovascular systems. CVP monitoring in these situations allows for rapid *adequate* replacement of blood, as it is lost, so that there is proper cardiac, cerebral, and renal tissue perfusion throughout the procedures.

Conditions in which difficult fluid and electrolyte problems exist, such as intestinal obstruction, pancreatitis, and peritonitis may be more vigorously managed with CVP monitoring. Here, large volume replacement is frequently necessary in desperately sick patients who can ill afford pulmonary edema. Rales and wheezes associated with allergic reactions, which occur not uncommonly in the management of these complex states, can be safely differentiated from pulmonary edema. This is particularly important in preventing a cessation of needed fluid in the mistaken attempt to treat pulmonary edema which does not exist.

The differential diagnosis of renal failure may be aided by the use of CVP monitoring, for a low initial reading suggests hypovolemia. A trial with appropriate fluid may then be undertaken to separate this diagnosis from obstructive uropathy.

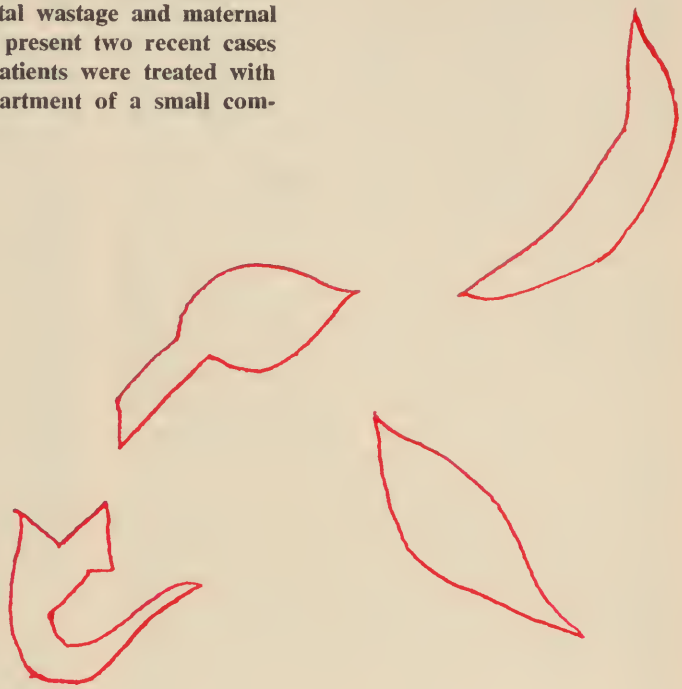
Summary

Central venous pressure monitoring is presented as an addition to the physician's armamentarium in the treatment of a variety of clinical problems. It is not to be used alone in the diagnosis or treatment of the situations discussed above despite its singular usefulness in many of these.

CVP monitoring is not a substitute for blood volume measurement, a *static* test, but rather a *dynamic* tool for the constant interpretation of the relationship between cardiac competence and blood volume. It should be used in all applicable situations, for it requires only simple inexpensive equipment readily available on every hospital ward, yet it yields reliable minute-to-minute information not available by any other single method regardless of cost or complexity.

References will be supplied upon request.

Sickle cell disease is a most serious hemoglobinopathy, complicating pregnancy and causing alarming rates of fetal wastage and maternal mortality. The purpose of this report is to present two recent cases of sickle cell anemia in pregnancy. Both patients were treated with lifesaving transfusions in the obstetrical department of a small community hospital.



Sickle Cell Disease in Pregnancy—

A Report on Exchange Transfusions



NORMAN LEVIN, MD, FACOG
Baltimore

DESIDERIA TABANAO-MAHUSAY, MD
Lutheran Hospital

Approximately 8% to 10% of the American Negro population carries the hereditary sickle cell trait, with the incidence of sickle cell anemia being one in every 576 Negroes. However, the disease is not nearly so common in pregnant Negro women, perhaps only one fourth to one third of the theoretically calculated frequency.[1] The shortened life span of the sickle cell disease patient apparently does not permit a substantial number of such patients to survive long enough to become pregnant.

Fortunately for the obstetrician, people with this trait usually have reduced fertility. Puckett, in his report, claims that the average number of pregnancies among women with this disease is only 2.1 to 2.7, as compared with the over-all pregnancy rate of 3.5.[2] In addition, the incidence of spontaneous abortion is almost four times greater in those women with sickle cell anemia than in those with normal adult hemoglobin.[3]

This disease is characterized by the presence of an abnormal hemoglobin type S and abnormally shaped red cells. Sickling most frequently occurs in the presence of a low oxygen tension and acidity, thereby causing log jams within the smaller radicles of the vascular tree. This vascular stasis leads to agglutination and thrombosis, which in the lungs causes an increased anoxia with perivascular hemorrhage and necrosis.[4] Infections in these people may be catastrophic, particularly respiratory infections, since infection is often the initiating agent precipitating hemolytic crises.

The blood of sickle cell patients usually contains 75% type S hemoglobin, with more than 60% being diagnostic. In the heterozygous state (S-A), type S hemoglobin constitutes less than 45% of the cell hemoglobin, the remainder being normal type A hemoglobin. The disease also exists in intermediate forms in conjunction with other abnormal types, designated types C, D, and G.

Case Reports

Case 1:

M. T., 27 years old, Negro, para 0-0-6-0, STS negative, type B positive, with EDC July 8, 1968. The patient had diagnosed SS type sickle cell anemia. With this last pregnancy, she had been hospitalized several times due to painful episodes of thromboembolic crises. Her hematocrit varied between 20% and 27%. She was taking a phosphorus-free vitamin and mineral dietary supplement, plus 1 mg of folic acid (*Filibon FA*). In the early part of her last trimester, the estimated fetal weight was less than the norm for that time. Twenty-four hour urinary estriol levels were as follows:

May 27, 1968—17.2 mg/24 hours
June 10, 1968—15.3 mg/24 hours
June 18, 1968—10.6 mg/24 hours

On July 2, 1968, she was admitted to the hospital because of painful and marked swelling of her feet and legs. Bed rest and diuretics were prescribed. Two days later her edema subsided, but large inflamed varicose veins appeared along the course of the great saphenous on both sides of her legs. In the evening of July 5th, she developed a low-grade temperature with cough, pain, and rales in the left chest. A chest film taken early the next day disclosed either basal pneumonitis or infarct. An exchange transfusion was performed with #16 angiocaths in each anticubal vein, with 1500cc of fresh packed red cells and 500cc of whole blood. At first, 200cc were withdrawn and then replaced with the same amount of fresh blood; later, simultaneous withdrawal and infusion were performed. The patient's vital signs, as well as fetal heart tones, were closely monitored. There was difficulty in the withdrawal because of blood clotting, and the procedure took seven and a half hours. Heparinization was instituted following the exchange. Pelvic examination revealed a FT dilated cervix, 50% to 60% effaced, and a floating vertex with intact amniotic sac. Immediately following transfusion, her temperature rose to 102° F, her sputum was blood-tinged, and her hematocrit climbed to 45%. False-labor uterine contractions were also observed. Another 24-hour estriol level was only 4.8 mg. Promptly, the patient was delivered by a cesarian section of a 5 lb 12 oz male infant with Apgar score of 9. The amniotic fluid was dark yellow in color, somewhat viscid, and less than the usual amount. Just before surgery, the patient was given 50 mg of protamine sulfate. Her postoperative course was uneventful. Heparinization was resumed on the first postoperative day. The patient was discharged 14 days postoperative and placed on anticoagulant therapy. The baby's condition was good.

Case 2:

This patient was a 20-year-old Negro girl, para 1-0-0-0, whose LMP was on March 22, 1968, and EDC December 29, 1968. She was a diagnosed sickle cell anemia type SS, and had had recurrent painful episodes and attacks of bronchial asthma since early childhood. Since the age of nine, she had been hospitalized for crises, asthmatic attacks and several blood transfusions.

On October 28, 1968, she was admitted to the hospital in painful crisis with uterine size compatible with that of 30-weeks gestation with a good FH. She was exchange transfused on October 31 with 1000cc of whole blood and 750cc of packed red blood cells, and 2000cc blood was withdrawn without complication. She was discharged on November 2 in satisfactory condition. Her pre-exchange transfusion hematocrit and hemoglobin were 19% and

7.2 gm respectively, while her post-exchange transfusion hematocrit and hemoglobin were 31% and 10.7 gm.

She was admitted again on December 2 in crisis and asthmatic attack, and gradually responded to symptomatic treatment. She complained that the baby was not moving and the uterus did not seem to be growing. Urinary estriol level on December 9 was found to be 17mg. Amniotic fluid was darkly meconeum stained. She was exchange transfused on December 10 with 500cc of packed red blood cells, and 890cc of whole blood was withdrawn. Her pre- and post-exchange transfusion hematocrit were 20% and 33% respectively. The cervix was long and closed. She was delivered by a low transverse cesarian section, followed by a bilateral partial salpingectomy and an incidental appendectomy under spinal anesthesia. The female infant weighed 2693 gm and had an Apgar score of 9. The amniotic fluid, though abundant in amount, was meconium stained. Both mother and child were in satisfactory condition until discharge on December 20.

Comments on the Cases

Prior to the use of exchange transfusions, Eisenstein et al, in 1966, reported 30 maternal deaths among 138 patients with sickle cell anemia, for a maternal mortality rate of 21.7% and a fetal loss rate of 41.9%.[5] Ricks, in 1968, reported seven exchange transfusions in sickle cell anemia in pregnancy during the third trimester—two of the exchanges performed as emergency procedures—with the survival of all seven mothers and seven infants.[6] Anderson noted that following exchange transfusion, the patient remains free from crisis for approximately 60 days. Presumably, the presence of normal donor cells in the patient's circulatory system protects against the precipitation of crisis. The nature of this protection is not known, but a likely mechanism is the effect of the transfused cell upon the patient's blood viscosity; by their presence, normal cells decrease the absolute number of sickle cells and thereby decrease viscosity.[7]

In both of the above reported cases, the exchange transfusions were performed as emergency procedures, when the usual therapeutic tools such as antibiotics, bed rest, analgesics, folic acid, and oxygen were not sufficiently arresting the disease. Cesarian section, a much more formidable mode of delivery than the usual vaginal delivery, could be performed because both patients had previously been protected by the exchange transfusion—red blood cells functioning like normal cells while in circulation. On the basis of persistent low urinary estriols in one case, and a markedly meconium stained amniotic fluid, plus a lack of fetal growth in the other case, immediate delivery was mandatory. Neither case suggested vaginal induction of labor. It is also interesting to note that the exchange transfusion did not improve the urinary estriol levels.

Exchange transfusions of less than the amount advocated by Ricks were utilized on two separate occasions, in Case 2 with satisfactory results. This technique is more practical than total exchange transfusions, because it is sometimes difficult to obtain the necessary amount of fresh whole blood, and it is exceedingly difficult to perform the exchange transfusions within the average time of 70 minutes mentioned by Ricks.

Finally, it should be stated that the benefits of the partial exchange transfusion are only temporary, since the half-life of a normal red cell is 120 days and the half-life of a sickle cell is only 60 days.

Summary

Two cases of sickle cell anemia are reported, with exchange transfusions being performed as emergency procedures during the third trimester. These transfusions were necessary only after it became obvious that the usual therapeutic tools were not effective in stopping the disease. In one particular case, two partial exchange transfusions were performed on the same patient. For obstetrical reasons, both patients had to be delivered by cesarian section and both mothers and infants survived.

REFERENCES

1. Eastman, H.: Obstetrics. 13th ed., p. 796.
2. Puckett, T. G.: Sickle Cell Hemoglobinopathy Associated With Pregnancy, *J S Okla Med Assoc* **59**: 15-19 (Jan) 1966.
3. Jenkins, M. E., and Clark, F. G.: Studies Into Maternal Influences on the Well-Being of the Fetus and Newborn. The Distribution of Abnormal Hemoglobin Among Pregnant Negro Women, *Amer J Ob & Gyn* **84**: 1 (July) 1962.
4. Lansford, K. G., and Stander, R. W.: Sickle Cell Anemia in Pregnancy, *Ob & Gyn* **16**: 197, 1960.
5. Eisenstein, M. I., Posner, C. A., and Frieman, S.: Sickle Cell Anemia in Pregnancy, *Amer J Ob & Gyn* **72**: 622, 1956.
6. Ricks, P. Jr.: Further Experience With Exchange Transfusion In Sickle Cell Anemia and Pregnancy, *Amer J Ob & Gyn* **100**: 1087.
7. Anderson, R., et al: Effects of Normal Cells on Viscosity of Sickle Cell Blood. In Vitro Studies and Report of Six Years Experience With Prophylactic "Partial Exchange Transfusion" Program *Arch Inter Med* **286**: 94 (March) 1963.

Phlebography in Leg Complaints

The first phlebograms were performed in man by Berberich and Hirsch in 1923, using Strontium bromide as the contrast material.[1] In 1931, Sgalitzer, Kolbert and Demel described a more acceptable technique.[2] Classic monographs on phlebography of the lower extremities were produced by Bauer and Hellsten in 1940,[3, 4] concerning their study of the effects of heparin therapy in thrombophlebitis. Accepted enthusiastically at first, the technique was soon abandoned due to difficulty with the radiologic technique, contrast material, injection sites, and equipment.

Early difficulty with interpretation of the films was probably due to use of insufficient amounts of dye to fill the venous system, and use of the supine position.[5] In spite of its loss of vogue, during the ensuing 45 years, several thousand phlebographic studies have been reported. As new techniques and contrast materials have appeared, renewed interest has developed. In 1967, Hershey, Magsaysay, and Aver reported their excellent and comprehensive study presenting results of more than 100 phlebograms of various types.[6]

The Mercy Hospital series of 100 phlebograms, begun in 1964 and continued through 1968, is an attempt to find a more logical approach to the treatment of varicose veins than those that have been reported in the literature. The Mercy program reinforces the previous conclusions. We have, however, been impressed by several of our own findings which are set forth in this communication. All of the patients were drawn from the author's private surgical practice, and the majority were studied in a single community hospital.

SALVATORE J. DEMARCO, III, MD, FACS
Attending Surgeon
Department of Surgery
Mercy Hospital

Acknowledgments: I wish to thank Thomas Cockey, MD, for his help in interpretations of the films, and his staff of X-ray technologists for their valuable technical assistance.

Method

The technique varies little from the accepted method, although the amount of contrast material is somewhat less and has varied as new products became available.

The patient is placed in a supine position on an X-ray table, the head end is elevated 30°, and a foot board is attached. Sufficient D-5-0.2 saline is infused through a 21 or 23 Butterfly, or pediatric scalp vein needle to insure that no infiltration will occur. After a 2ml test dose of Meglumine diatrizoate *(Renografin 60)* is infused, tourniquets are tied snuggly about the ankles 4cm above the tip of the malleoli. Thirty milliliters of contrast material is then injected by hand pressure over about a one minute period, and the 17″ × 14″ film in cassette beneath the lower legs and extending from ankle to the upper portions of the femoral condyles is exposed. Removing this and placing another cassette in the Buckey tray extending from the knee joint to inguinal area, requires approximately 20 seconds. This procedure is repeated a second time.

Subsequent to this, if only mild varicosities are evident, the patient is requested to push against the foot board five to seven times to milk the contrast material into unfilled vessels, and a third and fourth set of films is exposed.

Should marked varicosities be present, the patient may be tilted into a 5°-10° head down position, prior to exposure of the third and fourth sets, to overcome the tendency of the contrast material to pool in the lower extremities, dilute, and prevent proper visualization of the superficial femoral vein and its valves. Lateral views are obtained only if necessary. We do not hesitate to infuse 50 ml more dye if not satisfied with the results or to visualize the common iliac or Inferior vena cava. The latter requires a high thigh tourniquet to allow the dye to dam up, then suddenly flow as a bolus to the great vessel, similar to the method of Dale and Harris.[8] Dye is filtered out through the kidneys forming a nephro and pyelogram if desired. Approximately twenty minutes are required for the entire procedure. The only contraindications are known allergy to the dye, and strong history of drug reaction, or other allergies.

Case Presentations

L. C., this 40-year-old woman had vague aching in anterior lower leg and ankle. No definite pathology could be located. On the basis of similar clinical pictures, phlebography was performed revealing an essentially normal venous system with one anomalous deep vein, similar to that found in about 10% of this series. (Fig. 1, A & B)



Figure 1: A—Note anomalous deep vein of thigh; normal calibre and valve structure in these veins.



Figure 1: B—Normal communicating veins filling from the greater saphenous.

A. H., this 50-year-old woman was plagued with severe aching in the (R) lower thigh and intermittent cramping in the upper calf, for a six-year period. She had been treated for muscle spasm, myositis, arthritis and "nerves." Examination of the legs revealed a few scattered capillary bursts, but no obvious evidence of venous disease. Phlebogram

revealed markedly dilated incompetent communicators, and varicosities in both muscular and subcutaneous tissues. From the first postoperative day, to the present, three years later, she has remained totally asymptomatic. (Fig. 2)



Figure 2: Note the very incompetent communicators muscular and subcutaneous varicosities.

J. I., this 30-year-old religious brother, had known varicose veins of the legs for several years. For one year prior to surgery, he began to experience claudication-like pain in the (R) calf on prolonged standing and often in the recumbent position, which improved somewhat on exercising or elevating the legs. On examination, moderate superficial varicosities were present. The peripheral pulses were normal and equal. Two years after multiple ligation and stripping, using phlebograms to locate the communicators and deep varicosities, he is asymptomatic. (Fig. 3)

M. M., this 25-year-old operating nurse was well until eight months prior to surgery, when she began to notice recurrent swelling in the (R) lower leg and ankle with progressive aching and cramping. Symptoms were relieved by elevating the foot, and exacerbated by prolonged standing. She had recently been started on an oral estrogen-progesterone compound. Thorough physical examination, including gynecological consultation, revealed only a (R) leg and ankle 0.8 cm larger than the left, with good peripheral pulses and scattered capillary bursts. Phlebogram revealed moderately severe muscular and subcutaneous varicosities and incompetent communicators. A repeat phlebogram six months later,



Figure 3: Note filling of communicators from the deep circulation.

revealed an increase in the incompetency of the superficial communicating venous system. Two weeks following ligation and stripping, she returned to work to stand all day, the (R) leg having decreased in size till it was smaller than the (L). She remains asymptomatic three months post surgery. (Fig. 4)



Figure 4: Again the dilated perforators and deep varicosities are evident.

V. H., this 50-year-old woman who denied previous deep vein thrombosis, had undergone ligation and stripping in 1958, with subsequent development of superficial varicosities and edema, worse on the (L). Phlebogram revealed defects in the anterior tibial veins, bilaterally, which the author has attributed to the pressure of the cassette on the calves. Meticulous dissection of the superficial varicosities, with removal of the lesser saphenous system, resulted in bilateral edema beginning on the first ambulatory day without elastic stockings. Presently, after six months of wearing measured Jobst (R) stocking, the edema is 90% improved. New superficial veins are becoming obvious, not yet dilated or tortuous. (Fig. 5)



Figure 5: Four cm defect is present bilaterally. Proximal portion fills retrogradually, distal end has sharp cut off.

H. M., this 45-year-old man had diffuse and markedly dilated superficial veins, which he could observe to extend and enlarge daily. Though some tiredness was present at times, he was essentially asymptomatic. Phlebography revealed a superficial femoral and popliteal vein 1.5cm in diameter, larger than the upper limits accepted as normal in this small series. For this reason and because competency of the valves was questionable, the greater saphenous was preserved. Multiple ligation and stripping of the varicosities was performed. He remains asymptomatic. (Fig. 6)

M. V., this 35-year-old woman underwent ligation and stripping of the greater saphenous system in 1964. Following the last pregnancy, new and uncomfortable varicosities developed. Examination revealed mild superficial varicosities with one prominent 12cm vein in the (R) thigh, subjectively the most troublesome. Contrast material was injected through a varicosed calf vein without a tourniquet and drained directly to the deep as well as superficial circulation. Many of these varicosities were probably present during the previous surgery, but were not visible on inspection of the legs. Surgery was deferred until a later date. (Fig. 7)



Figure 6: Superficial vein is dilated and valves poorly visualized.



Figure 7: The large tortuous intradermal vein is very symptomatic and promoted surgical consultation.

Discussion

Venous disease of the lower extremities, present in more than 10% of the population over 35 years of age, may be familial, congenital and acquired. Women seem to be more widely affected than men, and in our series, predominated two to one. Observations of our patients suggests to us that hormonal levels play a large part in the development or aggravation of varicose changes. A significant number of these women in careful questioning, revealed that their symptoms are worse during the part of their menstrual cycle when hormonal levels are at their peak. Pregnancy aggravates venous diseases of the lower extremities from soon after conception, while the uterus is small, to several weeks after delivery. Only relatively late in the pregnancy does mechanical compression play a significant part.

Exogenous increase of hormones also seems involved in aggravation of the signs and symptoms. With the exception of that secondary to thrombophlebitis, pure acquired venous disease of the low extremity seems relatively rare. Here there is destruction of the valves and either recanalization with incompetency of the vessel or obliteration. Secondarily, there is an increase in hydrostatic pressure in the communicating and superficial veins out to the capillaries of the skin. Theoretically, destruction of the sapheno-femoral junction valve, from whatever cause, could result in a retrograde weakening and incompetency of the remaining deep valves with subsequent destruction of the superficial system. This has been advanced as the cause of most cases of varicose veins of the lower extremities.

In our series, however, 90% of the phlebograms displayed superficial femoral veins of a normal calibre with competent valves. Eight percent had either obvious thrombosis or no valves visualized due to rapid run off. Only 2% of the deep vessels were significantly dilated (1.5cm or greater) with apparent incompetent valves and no history of previous thrombosis.

The most impressive phlebograms were the 15% in which either totally unexpected problems, or much more advanced venous disease, was present than was suspected clinically. In general, such clinical tests as those of Trendelenberg, Pratt and Perthes did not correlate well with this series of patients.

As our study has progressed, it has become abundantly clear that the clinical appearance of the leg is a poor indication of the extent of involvement of subcutaneous intramuscular and communicating veins.

Six percent of our patients had only scattered capillary bursts on the skin of the involved extremity, but experienced much subjective discomfort. In all, the most important phlebographic finding was significantly enlarged and tortuous communicators filling from the deep circulation. Ligation and stripping including these communicators has resulted in complete relief.

We recommend phlebography on any patient with unexplained pitting edema of a lower extremity, vague complaints of discomfort or capillary bursts which cannot be accounted for by other means.

We have not found the method of Arnoldi [7] (interosseous phlebography) to be necessary in this series, and have limited experience in cineradiography which requires more time, more irradiation, and more elaborate equipment than is present in most community hospitals.

Conclusion and Summary

Venous blood flows from the superficial to the deep circulation of the lower extremities and does not regurgitate unless valvular incompetence is present. When it does, signs and symptoms develop. It is our impression, from this small series, that venous incompetence is more common than realized, and is often diagnosed as another disease process when varicosities are not evident. In the last four years, we have performed 100 phlebographies and have been impressed by the simplicity and value of this technique:

1. **it reveals situations where surgery is contraindicated;**
2. **it may reveal varicose changes where more serious disease processes are feared;**
3. **it may save the patient from the brand of "psychoneurotic" when persistent vague leg complaints persist, despite an essentially normal history of physical examination, and various types of treatment;**
4. **it presents a direct picture of the extent of venous disease and its location;**
5. **it allows the surgical approach to be tailored to the patient;**
6. **it may help prevent future frustrations of patient and surgeon by preventing or delaying recurrence;**
7. **it may be performed in any community hospital either as an outpatient, when surgery is not contemplated, or as an inpatient if it is.**

REFERENCES

1. Berberich, J., Hirsch, S.: Die Röntgenographische Darstelling der Arterien und venen am lebenden menschen. *Klin Wschr.* **2:** 2226, 1923.
2. Sgalitzer, M.; Kolbert, V.; Demel, R.: Konkrast-darstelling der venen in röntgenbilde. *Klin Wchnsehr* **10:** 1659, 1931.
3. Bauer, G.: A venographic study of thrombo-embolic problems. *Acta Chir Scand* **84:** 1, 1940.
4. Hellsten, W. O.: Phlebography studies and heparin treatment in thrombo-embolic disease. *Acta Chir Scand* **86:** 1, 1942.
5. Hecher, S. P.; Kramer, R. A.; Weigen, J. F.: Clinical value of venography of the lower extremity. *Ann Int Med* **59:** 798, 1963.
6. Hershey, F. B.; Magsaysay, G.; Aver, A.: Phlebography in diagnosis and management of venous diseases of the legs. *Med Clin N Amer* **51:** 161, 1967.
7. Arnoldi, C. C.: A comparison between the Phlebographic picture as seen in dynamic interosseous phlebography and the clinical signs and symptoms of chronic venous insufficiency. *J Cardiovascular Surg* **2:** 184, 1961.
8. Dale, W. A., Harris, J.: Cross over vein grafts for Iliac and Femor venous occlusion. *Ann Surg* **168:** 3, 319, Sept. 1968.

For information or reprints write: 103 Witherspoon Rd., Baltimore, Md. 21212.

In February of 1968 the Baltimore City Health Department was asked to participate in a nutritional survey of all children in the Comprehensive Care Clinics across the country. This was to be a cross-sectional study of all the infants and children who appeared for any reason at each center during the months of March and April of 1968. It presented us with a good opportunity to study our own population in Baltimore. The figures which follow were the survey forms of the first 2,000 children.

The Nutritional Status of C/Y* Center Children



ALEXANDER J. SCHAFFER, MD
Assistant Commissioner of Health
Baltimore City Health Department

**Children/Youth*

For several reasons the results of this study cannot be considered conclusive. First, the numbers are not always statistically significant when they are broken down into the four centers and into various age groupings. Second, the presumed norms for the average middle-class population of the U. S. may not, for various reasons, be applicable to this group. Third, the haste imposed upon us by the lateness of the request rendered inevitable an undetermined number of errors. The most obvious of these we have discarded, but we are afraid that others may have been included. Analyzed in the simplest fashion were the following:

Center	Weight	Height	Hemoglobin
606-A	585	566	187
606-B	697	679	142
606-C	328	326	172
606-D	261	261	...
Totals	1871	1832	501

Weight: Figure 1 shows the distribution of the highest and lowest quartiles with respect to the weights of 1,860 children, translated into their calculated percentiles for age and sex. No distinction has been made with respect to race. Nor were children of low birth weight segregated. Table 10 of Nelson's Textbook of Pediatrics [1] was used for calculating percentiles. Keeping the earlier reservations in mind, it is apparent from Figure 1 that considerably more of our infants and children fall into the lowest quartile than the 25% expected, at least up to the age of approximately ten years. From then until 18 years of age this number falls, so that the distribution by quartiles in the later teen years approaches normalcy.

It seems safe to assume that there exists an excess of infants and young children whose weights are lower than they should be, whereas older children do not show this excess. Possible explanations are that more of the low-weight children die, or that many of these babies catch up as the years pass, or possibly that an excessive number of children in this population become obese.

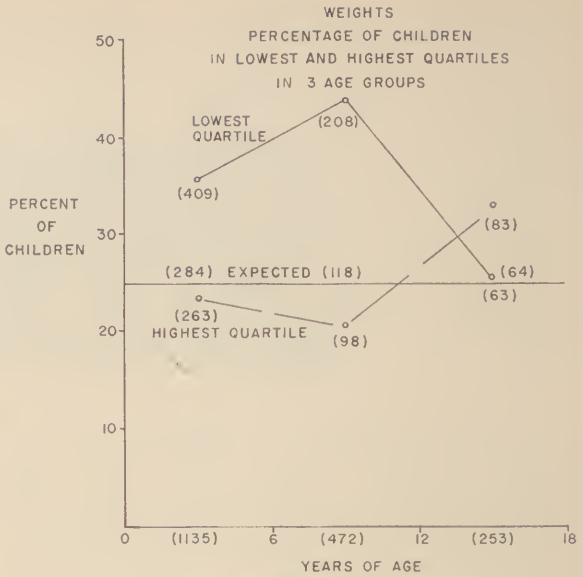


Figure 1

Figure 2 breaks down the total in the lowest quartile into its four component C/Y Centers. There appears to be good consistency among them, and the ranges are not excessive considering the small size of the groups. It was anticipated that 606-D might differ considerably from the others in that it alone is composed very largely of white children, but it is unlikely that any of the differences seen are significant.

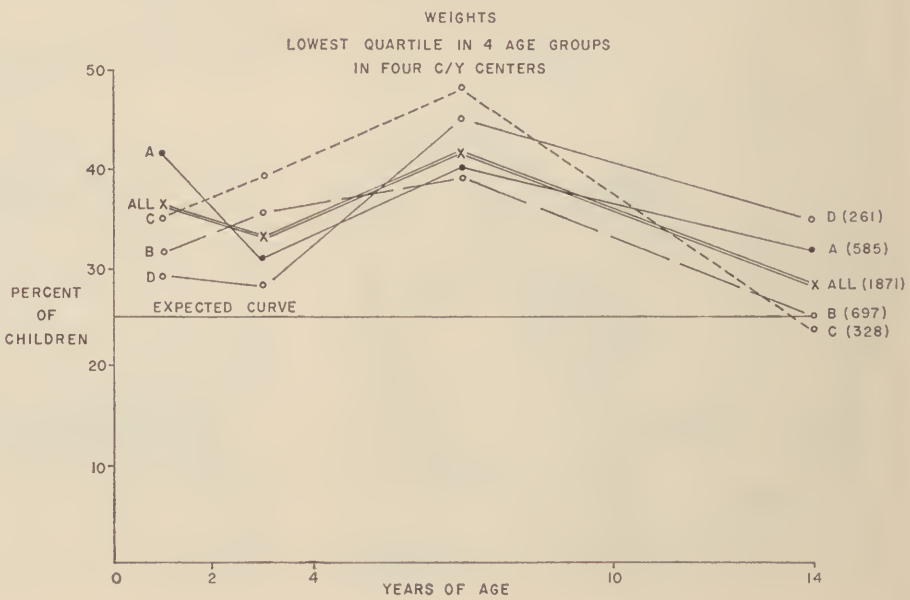


Figure 2

Height: Again one sees, in Figure 3, the excess of first quartile heights over the expected. The curve up to 12 years is not much different from that depicting weights, but in the 12- to 18-year period it does not return as close to the normal as does the weight curve. We must record many more weight-height observations of this nature, for this conclusion will be highly important if it can be verified.

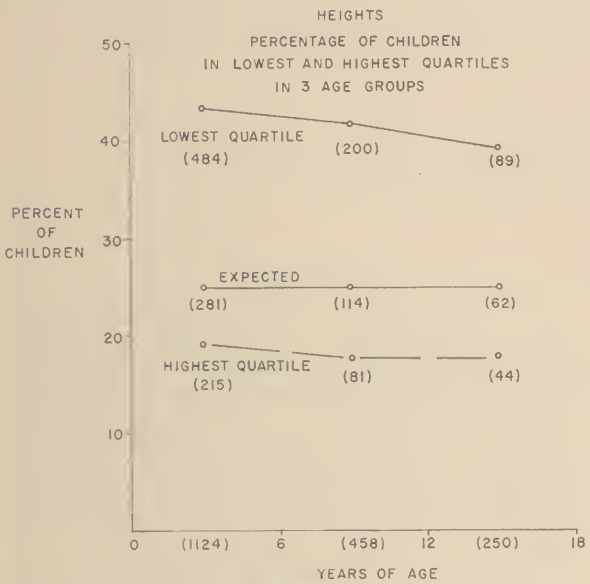


Figure 3

Third Percentiles for Weight and Height

An even more sensitive index of failure to thrive and grow at the usual rate should be the number of children who fall into or below the third percentile range. Figure 4 demonstrates the remarkable excess in our population in this lowest category, with a spread of from four times the expected number in one center to six times as many in another with respect to weight. The figures for height are even more surprising—from six times expected in one center to nine times in another! Figure 5 breaks down the heights into three age groups—0 to 6, 6-12, and 12-18 years. Again one sees the sevenfold excess of stunted children in the first six years of life, rising slightly, but possibly significantly, in the second six-year period, and then falling in the 12-18 year age group to a four-times expected figure.

Relation of Later Height to Birthweight

We wondered whether the excesses of short stature discovered in infancy and childhood were due to an original excess of low-weight babies. Fortunately this question could be explored. (See Figure 6). Exactly one fifth had weighed 2500 g or less at birth, and only a few less of the total

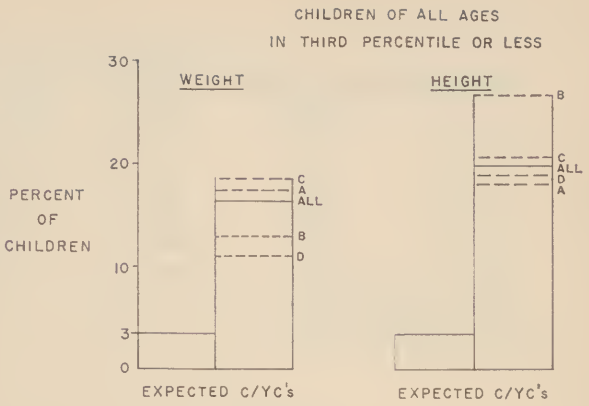


Figure 4

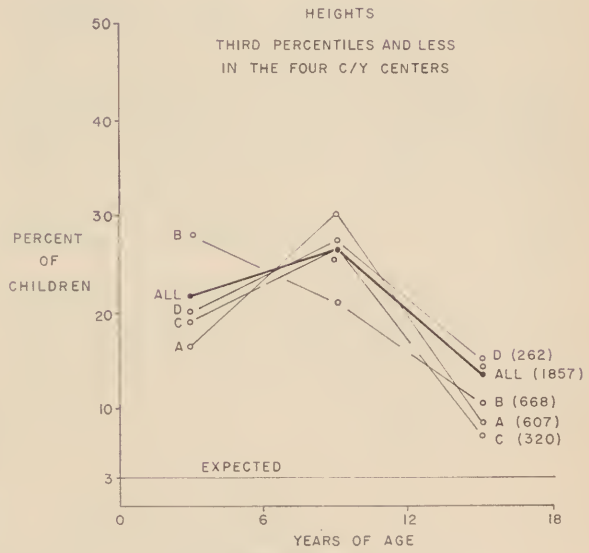


Figure 5

fell into the third percentile or lower for height grouping when measured at a later date. But it is not this simple. One third of those who started life as low birth weight infants are identified later as third percentile for height, while one sixth of those who began as mature infants weighing more than 2500 g also ended up in this same low height category. In 606-D, where the population is predominantly white, the rate of "prematurity" was found to be 12%, quite unlike the 18% to 22% rates found in the other predominantly nonwhite centers. Yet 606-D's figure for third percentile children later in life turns out to be considerably higher than those of the other three C/Y centers. It is hard not to conclude that much of the stunted growth in our indigent population is acquired, and is not dependent upon low weight or immaturity at birth.

Figure 6: NUMBERS OF THIRD PERCENTILES FOR HEIGHT AS RELATED TO LOW OR HIGH BIRTH WEIGHTS

C/Y Center	Total Number	Third Percentiles	Began Life as Low BW's	Third Percentiles	Began Life as Full Term	Third Percentiles
[1]606-A	498	18.4%	22.7%	40.7%	77.3%	11.9%
[1]606-B	405	18.7%	22.7%	30.4%	77.3%	15.3%
[1]606-C	309	19.4%	18.1%	26.8%	81.9%	17.7%
[2]606-D	221	20.3%	12.2%	22.2%	77.8%	20.1%
Total	1,433	19.0%	0.1%	32.9%	81.0%	15.5%

[1]Predominantly nonwhite.
[2]Predominantly white.

Hemoglobin Concentrations: Figure 7 demonstrates the findings with respect to hemoglobin determinations in the four Comprehensive Care Clinics. The presumed normal curve was again constructed from Nelson's Textbook of Pediatrics.[1] Five hundred one determinations were made among these same 2,000 infants and children. It will be seen that in the population under study the mean hemoglobin level ranged from 1.0 to 2.0gm below the presumed normals.

Time has not permitted an analysis of the hematocrit levels obtained during this same study, but a hasty survey indicates that they too will demonstrate the same degree of anemia as do the hemoglobin concentrations.

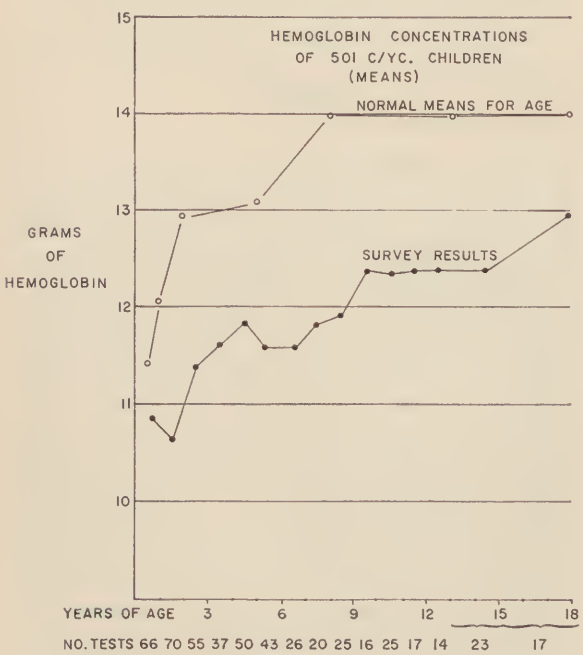


Figure 7

Summary

This unsophisticated analysis of the nutritional status of approximately 2,000 children in our four C/Y Centers can only strengthen our conviction that many of them have been and still are nutritionally or culturally deprived or both to the point of retardation of normal physical growth. One can only guess at, and be horrified by what this same deprivation may have done to their intellectual growth.

I have little doubt that similar findings would come to light if we studied our Well-Baby Clinic clientéle in the same way, whether they be the usual clinic population or the presumably élite Project 501 infants and children.

All of us, pediatricians, public health nurses, nutritionists and our paramedical assistants, must realize that this is our primary task. If we cannot do a better job on the nutrition of our infants and children how can we expect to accomplish anything worthwhile in the infinitely more complicated tasks concerning their intellectual, emotional and social development?

REFERENCE

1. Nelson: Textbook of Pediatrics, 8th Ed., Harvard School of Public Health, pp. 48-53, 1007.

your medical faculty at work

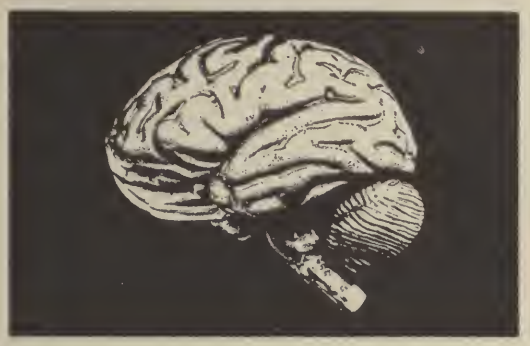
by John Sargeant
Executive Secretary

The Executive Committee met on Thursday, October 30, 1969, and took the following actions:

1. Designated various members for appointment to the Physicians' Review Committee of Blue Cross;
2. Selected dates for 1970 Executive Committee and Council meetings;
3. Set the date of Saturday, December 13, 1969, at 2:00 pm for a special meeting of the House of Delegates to consider Bylaw changes in connection with provision of legal defense for Faculty members;
4. Declined again to designate a member of the Administrative Committee, Regional Medical Programs;
5. Authorized appointment of various members to serve on an Advisory Council on Human Trials which would act as a group in advising the Secretary of Health and Mental Hygiene on these problems;
6. Confirmed that appropriate action was taken in connection with rendering advice and consultation to Blue Shield plans on Medicare services by certain physicians;
7. Determined that a question of Health Data Processing Activity in connection with utilization review and peer review activities was one that should be determined by local medical staffs in hospitals;
8. Adopted a revised Nurses Protocol as recommended by the Nurses Liaison Committee;
9. Approved a proposed Sports Curriculum for Sports Trainers, as recommended by the Subcommittee on Sportsmedicine;
10. Approved the mailing of a letter to members in selected components regarding the medical evaluation form for students planning to participate in Interscholastic sports programs;
11. Determined that AMAERF contributions would be channeled through the Woman's Auxiliary so that this group could obtain credit for such contributions made by Faculty members;
12. Designated a representative to attend a meeting with the State Health Department to discuss General Hospital Professional Components under Title 19 programs;
13. Adopted a revised policy recommendation to the Council in connection with provision of Laboratory Services.



MARYLAND STATE MEDICAL JOURNAL, published monthly by the Medical and Chirurgical Faculty of Maryland, 1211 Cathedral Street, Baltimore, Maryland 21201. C. Thomas Flotte, MD, Editor; Judith E. Sowell, Managing Editor. Editorial offices—1211 Cathedral Street, Baltimore, Maryland, 21201. Owned by the Medical and Chirurgical Faculty of the State of Maryland. No known bondholders, mortgagees, or other security holders. Total number of copies printed—4330 (average number of copies each issue during preceding 12 months), 4400 (actual number of copies of single issue published nearest to filing date). Paid circulation through dealers and carriers, street vendors and counter sales—none, through mail subscriptions—3800 (average number), 3971 (actual number). Total paid circulation—3800 (average), 3971 (actual). Free distribution (including samples) by mail, carrier or other means—246 (average), 255 (actual). Total distribution—4046 (average), 4226 (actual). Office use, left-over, unaccounted, spoiled after printing—284 (average), 174 (actual). Sum total—4330 (average), 4400 (actual).



JAMES E. CARSON, MD, COMMISSIONER
KURT GORWITZ, ScD, STATISTICS DIRECTOR

Maryland State department of mental hygiene

Diagnostic Treatment Trends

Nearly half of the 11,997 admissions to Maryland's psychiatric hospitals in 1968 were for the treatment of alcoholism. The number of such admissions has more than tripled in the last six years (from 1,785 in 1962 to 5,957 in 1968). Preliminary data for 1969 indicate that a majority of the 14,085 admissions were alcoholics. However, since virtually all are released after a short period of hospitalization, the proportion of all residents diagnosed as alcoholics increased also but reached only 10.5% by 1968.

	ADMISSIONS DURING YEAR		RESIDENT PATIENTS AT END OF YEAR	
PSYCHIATRIC DIAGNOSIS	1968	1962	1968	1962
TOTAL—NUMBER	11,997	6,221	7,624	7,945
PERCENT	100.0	100.0	100.0	100.0
ALCOHOLISM	49.2	28.6	10.5	5.6
OTHER PERSONALITY DISORDERS	8.2	6.2	4.0	3.0
PSYCHONEUROTIC REACTIONS	6.3	6.8	2.5	1.9
SCHIZOPHRENIA	14.3	27.8	40.8	46.9
OTHER PSYCHOTIC DISORDERS	3.0	5.7	4.9	6.5
DISORDERS RELATED TO OLD AGE	5.3	11.7	13.9	14.1
MENTAL RETARDATION	1.1	2.5	7.3	9.7
ALL OTHERS	12.6	10.7	16.1	12.3

The number of admissions with a diagnosis of schizophrenia declined slightly from 1,738 in 1962 to 1,730 in 1968. Proportionally, this represented a drop from 27.9% to 14.3%, the lowest level in recent years. Although the number of chronic, long-term schizophrenics has been decreasing for some time, they continue to occupy two out of every five beds. A similar trend occurred for patients with other psychotic diagnoses. In 1968 these accounted only for 3.0% of all admissions and 4.9% of all residents.

Admissions for disorders related to old age have gradually decreased in recent years and are now only 5.3% of all patients entering care. This undoubtedly reflects the expansion in nursing homes and other community care facilities. Most remain hospitalized until ultimate death and they occupy 13.9% of all hospital beds.

Although Maryland has two hospitals for the mentally retarded, there were 129 retarded admissions and 553 resident patients in psychiatric hospitals during 1968. Most retarded residents have been hospitalized for some time and releases are mainly among recent admissions. The decline in the number of retardates in psychiatric hospitals is mainly due to deaths and to transfers to Rosewood and Henryton.

While most admissions are now for the short-term treatment of acute nonpsychotic disturbances, the majority of state hospital beds continue to be occupied by chronic, long-term psychotic patients. Since the number of releases in this group continues to be small, it must be expected that they will require a substantial proportion of hospital services in future years unless new methods of treatment and care are available.



Ornade® Spansule®

brand of
sustained release capsules

Trademark
Each capsule contains 8 mg. of Teldrin® (brand of chlorpheniramine maleate); 50 mg. of phenylpropanolamine hydrochloride; 2.5 mg. of isopropamide, as the iodide.

Prompt relief from nasal congestion and hypersecretion due to colds.

Before prescribing, see complete prescribing information in SK&F literature or *PDR*.
Contraindications: Glaucoma, prostatic hypertrophy, stenosing peptic ulcer, pyloroduodenal or bladder neck obstruction.
Precautions: Use cautiously in the presence of hypertension, hyperthyroidism, coronary artery disease; warn vehicle or machine operators of possible drowsiness.
Usage In Pregnancy: Use in pregnancy, nursing mothers and women who might bear children only when potential benefits have been weighed against possible hazards.
Note: The iodine in isopropamide iodide may alter PBI test results and will suppress I^{131} uptake; discontinue 'Ornade' one week before these tests.
Adverse Reactions: Drowsiness; excessive dryness of nose, throat or mouth; nervousness; insomnia. Other known possible adverse reactions of the individual ingredients: nausea, vomiting, diarrhea, rash, dizziness, fatigue, tightness of chest, abdominal pain, irritability, tachycardia, headache, incoordination, tremor, difficulty in urination. Thrombocytopenia, leukopenia and convulsions have been reported.
Supplied: Bottles of 50 capsules.

One capsule q12h for round-the-clock relief

SK&F Smith Kline & French Laboratories

ROBERT E. FARBER, MD, MPH, COMMISSIONER

Baltimore City health department

New Appointment

Dr. Guarnieri—Division for the Handicapped

Susan R. Guarnieri, MD, has been appointed Clinical Director of the Division for the Handicapped in the Child Health Services section of the Baltimore City Health Department. In this post Dr. Guarnieri will be responsible for the evaluation and follow-up of handicapped children referred for assistance by physicians and by official and nonofficial agencies. Since the greatest number of children are referred by schools her work requires close cooperation with the Health Department's Bureau of School Hygiene and Bureau of Public Health Nursing as well as the special services divisions of the city public and parochial schools.

Dr. Guarnieri, a native of Youngstown, Ohio, attended St. Mary of the Springs College in Columbus and received her MD degree from the Ohio State University College of Medicine in 1966. Completing internship at Mt. Carmel Hospital in Columbus in 1967, Dr. Guarnieri held a one-year residency in public health at the Philadelphia Department of Health followed by attendance at The Johns Hopkins School of Hygiene and Public Health where she obtained the Master of Public Health degree in June 1969.

The City Health Department's Division for the Handicapped registered 1,575 children last year and referred 189 youngsters with multiple handicaps to the Diagnostic and Evaluation Centers at the Johns Hopkins and University of Maryland hospitals. Over 27,000 children have been registered by the division since the program was established with the assistance of the Division of Crippled Children's Services of the Maryland State Department of Health in 1956.

Dr. Guarnieri's office is on the second floor of the American Building, Baltimore and South Streets, telephone 752-2000, extension 753.

New Recreation Center for Alcoholics

On October 20th the City Health Department dedicated a Recreation-Treatment Service for alcoholic patients attending the city's Alcoholism Center.

Located in the basement of the Center building at 2221 St. Paul Street, the recreation room and its equipment was made possible through the efforts of the Center's Community Advisory Board chaired by Mr. Charles Duff, its House Committee under the chairmanship of Senator Julius Lapides, volunteer members of the Electricians, Plumbers, Carpenters unions, the Baltimore Building and Construction Trades Council, and anonymous donors.

According to A.M. Schneidmuhl, MD, Director of the Alcoholism Center, the Recreation-Therapy Service will fill a social need for alcoholics undergoing treatment. Many alcoholics complain of loneliness, and revert to former drinking habits out of boredom or inactivity.

The recreation room, by providing television, reading materials, games and other activities, will be a constructive diversion for such patients. Here alcoholic patients may find companionship, friendship, and sympathetic encouragement.

Furthermore, the new service, open evenings and weekends, will present additional opportunities for alcoholism counselors, students in the alcoholism training program and volunteers to involve patients in group discussions and lectures thereby reinforcing the daytime treatment at the Alcoholism Center.

Physicians who may wish assistance with their alcoholic patients may call Dr. Schneidmuhl, telephone 752-2000, extension 2756.



BOLTON HILL *Dinner Theatre*

"THE ODD COUPLE"
Nov. 18 — Dec. 14

"THE OWL and THE PUSSY CAT"
Dec. 31 — Jan. 25

Dinner — 7 P.M.
Performance — 8:30 P.M.
FREE PARKING
CLOSED MONDAYS

THE FOURTH ACT
COCKTAIL LOUNGE
5 PM — 2 AM

for Reservations
call 728-0800

Baltimores Only Professional Dinner Theatre

A Bit of Spain in Baltimore's *Superb* Spanish Restaurant

RESTAURANTE TIO PEPE

For a never-to-be forgotten experience in Gourmet Dining

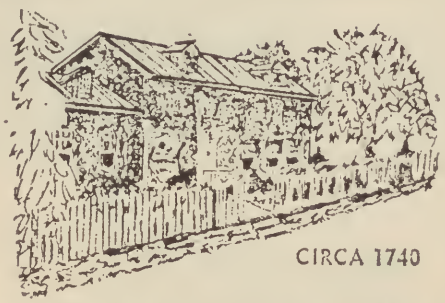
Our wine list includes the finest vintages

RESERVATIONS ARE A MUST

Call **539-4675**

Mon. thru Thurs. Lunches 11:30-2:30 Fri. & Sat. Dinner 5 PM-11:30 PM
Dinner—5 PM-11:30 PM Sun. Dinner 4 PM-10 PM

10 E. FRANKLIN ST., BALTIMORE, MD. 21202



THE MILTON INN

One of America's Internationally Famous Inns

Dine Amid Tradition in an Atmosphere of Historic Charm

Most Complete Wine Cellar in Maryland

Finest French Cuisine

For Reservations . . . call

771-4366

3 miles north of Cockeysville on York Rd.
SPARKS, MARYLAND

Brentwood Inn

FRENCH CONTINENTAL CUISINE

Smorgasbord Luncheon and Dinner every Tuesday . . . . .

"Home of Maryland's Internationally Famous Wine Cellar" . . . .

We honor all preferred Credit Cards

● ***NEW!*** Another Dining Room has been added to accommodate our many guests ●

OPEN DAILY & SUNDAY 11 A.M. to 2 A.M.

Fifth Ave. & Brentwood—1 block N. E. of Dundalk and Holabird Ave. 1 mile from Holabird Ave. Exit of Baltimore Harbor Tunnel

We cater to Private Parties, Banquets and Dinners

AT. 5-0520 *Ample Free Parking* **BALTIMORE, MD. 21222**



歡迎

THESE CHINESE CHARACTERS MEAN

"WELCOME"

And we do welcome you with our utmost desire to serve you with the finest of gourmet cooking. Whether eating here or taking our food home, you will find our food and service a most pleasurable experience . . . and we welcome you on all your visits.

Chinese-American Cuisine

CARRY-OUT SERVICE SPECIAL LUNCHEON AND DINNER
PRIVATE DINING ROOM FOR PARTIES

OPEN DAILY, 11 A.M. to 3 A.M.
SUNDAY 12 noon to 3 A.M.

320 Park Avenue BALTIMORE, MD. 21201

Phone 685-6790

The Branding Iron

Luncheons—Dinners—Cocktail Lounge—Private Parties

Open Hearth

Roast Beef . . .
Charcoal Broiled Steaks and Chops
. . . and the finest selection of Seafood

Our Wine Cellar includes the largest assortment of imported wines, selected from the best vintages.

Loaf of Piping Hot Bread served with dinner

Route 140—Finksburg, Md.

833-6060 *848-1930*

THE EXECUTIVE CHRISTMAS PARTY

20 to 70 Guests



Open Bar 6 to 7:30 P.M.

HORS D'OEUVRES

Swedish Meat Balls in Curry Sauce
Lump Crab Meat Balls
Chicken Liver Wrapped in Bacon
Cheddar Cheese and Crackers

APPETIZER

Crepe Rangoon
Caesar Salad
Individual Loaf of Home-made Bread served with May Wine

ENTREE

Roast Eye of the Prime Rib
Home-made Lasagna
Broccoli in Butter Sauce
Glazed Belgian Carrots
Sparkling Burgundy

DESSERT

Ice Cream Parfait with green Creme de Menthe

IRISH COFFEE

9 P.M. to 10 P.M. Open Bar
Sing-along Piano-player

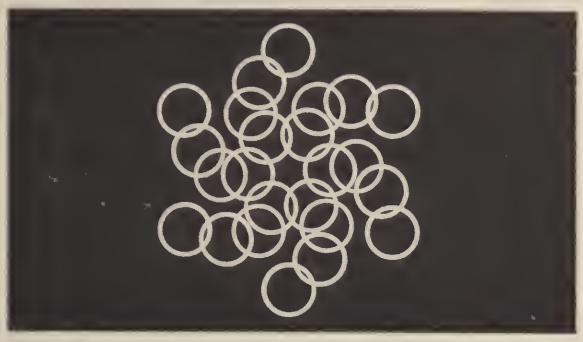
Only $17.50 per person
(price includes tax and gratuity)

CORK 'n' BOTTLE
RESTAURANT

Phone Reservations
539-1268

22 E. FAYETTE ST.
BALTIMORE, MD.


Greenery
'tis the Season!
in Historic Olney, Maryland
SUGAR PLUMS
STOCKING STUFFERS
GOURMET GADGETS
IMPORTED TOYS
CALICO APRONS
PERFUMERY
ANTIQUE SILVER & CRYSTAL
OLD VICTORIAN BRIC-A-BRAC
PARISIAN BOUTIQUES
MECHANICAL TOYS & GAMES
MINIATURE TOYS
TEA CUPS
GOURMET FARE
CANDLERY
DECORATIONS
MEET THE FRIENDLY FOLK!
SEE WHAT SANTA LEFT IN THE BARN!
CELEBRATE WITH OUR WINTER JULEP
GET THE HOLIDAY EDITION OF THE OLNEY ALMANAC
WINE & DINE
HOLIDAY CANDLES IN A HUGE SELECTION
EXPLORE THE COUNTRY STORE AND BARN SHOP
ENJOY SPECIALITIES FROM WORLD-FAMED OLNEY INN'S MENU... BY A HEARTH FIRE!
HEAR JOHNNY PLAY WHITE CHRISTMAS
SING ALONG!
MUSIC BOXES
BAUBLES
HAVE A CUP OF HOT CHOCOLATE
COFFEE & SNACKS IN THE LOFT
ADMIRE MRS. HURST'S HOLIDAY BOUQUETS
BUY A COUNTRY HAM
SHOP FOR SUGAR PLUMS
SEE THE FAMOUS OLNEY INN CHRISTMAS TREE!
TRINKETS
PLAY A GAME OF CHECKERS
RUMMAGE IN THE PARLOR BOUTIQUE
BUY A NICKEL'S WORTH OF PENNY CANDY
JAMS JELLYS
CRACKER
SIP A HOT TODDY!
FIND RARE ANTIQUES
SILVER
ART
GEE-GAWS
SPOOL BEDS
SEE MAGGIE'S GIFT EMPORIUM
VISIT MRS McLAURYS COUNTRY STORE "EVERYTHING FOR EVERYBODY"
BUY FRESH BAKED GOODS
GATHER HOLIDAY GREENS
FIND GIFTS AND GADGETS YOU THOUGHT THEY'D STOPPED MAKING!
MECHANICAL TOYS GALORE!
CURIOS
ROCKING HORSES
and for memorable holiday dining it's
THE FUN PLACE TO CHRISTMAS SHOP!
HOLIDAY BILL O' FARE!
Olney Inn
BARN SHOP & COUNTRY STORE
in the heart of the friendly Country
HOORAY FOR THE PUMPKIN PIE!!
& THE FESTIVE BIRD
OPEN SEVEN DAYS A WEEK!
FROM D.C. OUT CONNECTICUT AVE. OR 16TH ST. TO GEORGIA AVE. NORTH, ROUTE 97 TO OLNEY, MARYLAND AND OLNEY INN
FROM BALTIMORE - ROUTE 40 TO 29 TO 108 THROUGH ASHTON TO OLNEY, MARYLAND'S WORLD FAMOUS OLNEY INN!
For Reservations, Phone: 929-1717



From the Subcommittee on Alcoholism of the Medical and Chirurgical Faculty of the State of Maryland

Guidelines for Admission of Alcohol-Dependent Patients to General Hospitals

In June 1966, the House of Delegates of the AMA reaffirmed a statement it had adopted ten years earlier on admitting alcohol-dependent patients to general hospitals.

That statement referred to the growing acceptance of the fact that such patients are ill and are a medical responsibility. This acceptance, coupled with improved treatment methods and increased knowledge of and experience with alcohol problems, have largely obviated previously cited objections to hospital admission.

The statement further emphasized the need for each patient to be evaluated individually, and for the possibility of admission to a hospital to be decided solely on the basis of the particular clinical indications observed in the patient at the time and as determined from his history. Exactly the same criteria are applicable to the alcohol-dependent person as to any ill person where hospitalization is being considered as requisite to medical management.

The following guidelines are offered to assist the examining physician in making his determination regarding admission to a general hospital:

(1) A patient who is diagnosed as "alcoholic" by a physician, or who is so known by the hospital or by other responsible agencies and individuals, should be admitted if he:

a. has an infectious disease;
b. has hyperthermia;
c. has a history of convulsions, or a poorly controlled convulsive disorder, and has been drinking;
d. is hemorrhaging or unconscious;
e. wants to be withdrawn from alcohol, either for the first time or after having relapsed to drinking;
f. has a disulfiram—alcohol reaction.

(2) A person should be admitted to a hospital either under the tentative diagnosis of alcoholism, or as a known alcoholic patient, as the case may be, when he:

a. is unconscious and has been drinking;

b. is agitated and tremulous to the extent of indicating an acute withdrawal syndrome;

c. has convulsions, hallucinations, or delirium tremens, manifesting a complicated withdrawal state;

d. is suffering from a disease recognized as related to alcoholism (eg, cirrhosis, neuropathy, pancreatitis) and wishes to be withdrawn from alcohol;

e. has a disease or post-traumatic injury usually not requiring hospitalization, but also has a history of prolonged drinking, or of heavy ingestion of alcohol immediately prior to the illness.

The psychiatric unit, rather than the general medical service, or psychiatric consultation should be considered in one or more of the following circumstances:

(1) the patient is overtly psychotic;

(2) the patient is so severely depressed that he is probably suicidal;

(3) the patient represents a serious management problem because he is extremely confused or has other behavioral difficulties that cannot be adequately managed on a medical or surgical service.

As with any patient, the alcohol-dependent patient should be discharged from the hospital as soon as such discharge is medically indicated. In each instance, however, appropriate plans should be made prior to discharge for continuing after-care at the hospital or by a private physician, or, as frequently will be required, for psychological and social rehabilitation by public and voluntary agencies.

This statement was approved by the Council on Mental Health. Reprint requests to AMA Council on Mental Health, 535 N. Dearborn St., Chicago 60610. Reprinted with permission of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION, *October 6, 1969, Vol. 210, No. 1, page 121.*

BALTIMORE OXYGEN SUPPLY CO., INC.

OHIO CHEMICAL DISTRIBUTORS

Therapy and Medical Gases
and Oxygen Tents
Resuscitators and Apparatus

Main Office & Plant: Linthicum, Md. 789-8100
Warehouse: 1611 Guilford Ave., Baltimore, Md. 727-4748
Branch: 2426 Linden Lane, Silver Spring, Md. 582-2094

MEDIC (Continued from page 31)

OTHER SPONSORS:

Medical and Chirurgical Faculty of the State of Maryland

State Department of Health

Hospital Council of Maryland

Participating hospitals:

Anne Arundel General, Annapolis
Baltimore City, Baltimore
Baltimore County General, Randallstown
Bon Secours, Baltimore
Calvert County, Prince Frederick
Carroll County General, Westminster
Church Home, Baltimore
Cumberland Memorial, Cumberland
Easton Memorial, Easton
Eugene Leland Memorial, Riverdale
Franklin Square, Baltimore
Frederick Memorial, Frederick
Greater Baltimore Medical Center, Towson
Harford Memorial, Havre de Grace
The Johns Hopkins, Baltimore
Kent & Queen Anne's, Chestertown
Keswick, Baltimore
Lutheran, Baltimore
Maryland General, Baltimore
Mercy, Baltimore
Montgomery General, Olney
North Charles General, Baltimore
Peninsula General, Salisbury
Physicians Memorial, LaPlata
Prince George's General, Cheverly
Provident, Baltimore
Sacred Heart, Cumberland
St. Agnes, Baltimore
St. Joseph, Baltimore
St. Mary's, Leonardtown
Sinai, Baltimore
Union Hospital of Cecil County, Elkton
Union Memorial, Baltimore
University of Maryland, Baltimore
Veterans Administration, Loch Raven, Baltimore
Washington County, Hagerstown

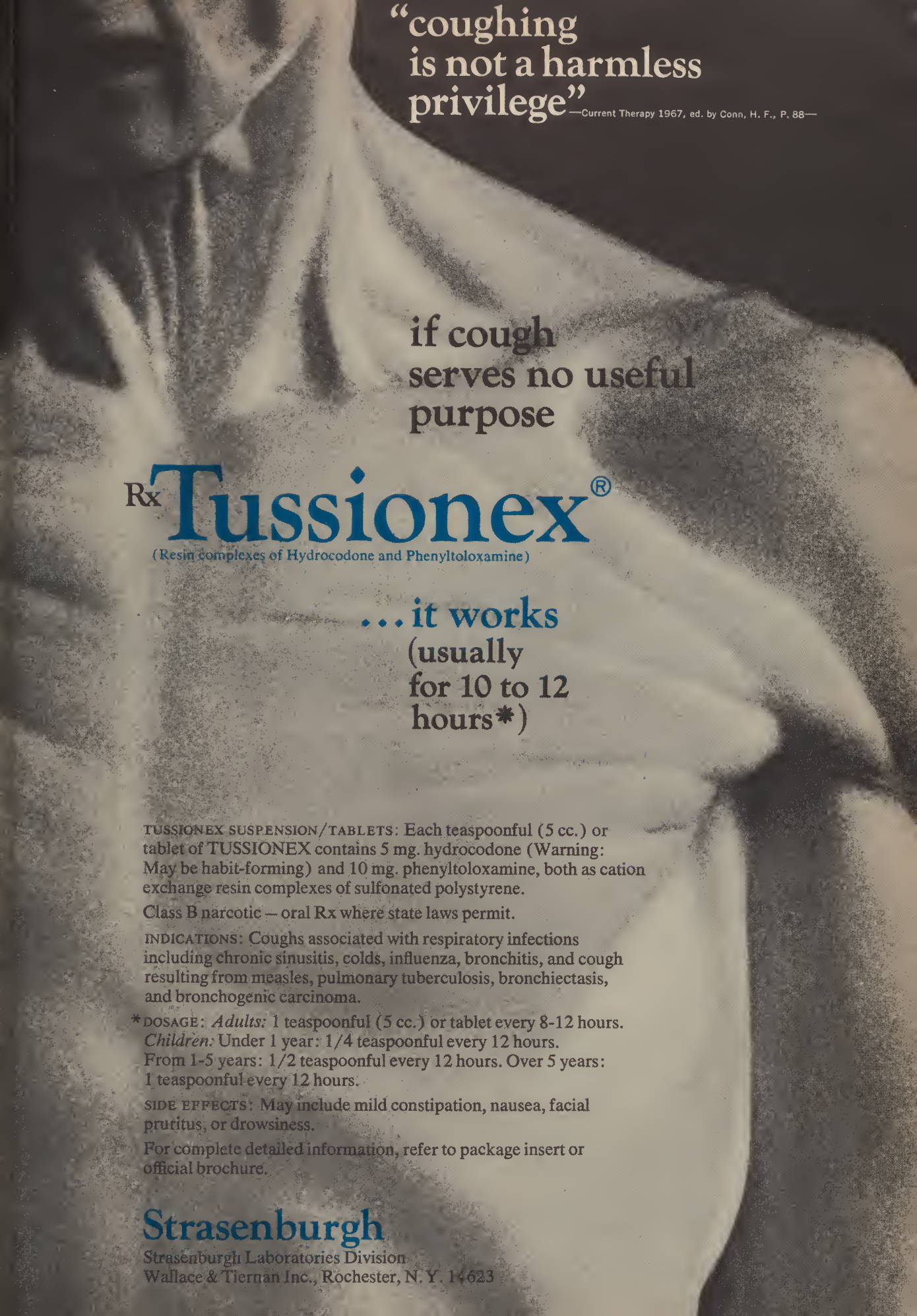
Other locations:

Baltimore County Health Dept., Towson
Civil Defense Headquarters, Baltimore
Hospital Council of Maryland, Inc., Baltimore
Medical and Chirurgical Faculty, Baltimore
State Department of Health, Baltimore

For further information contact:

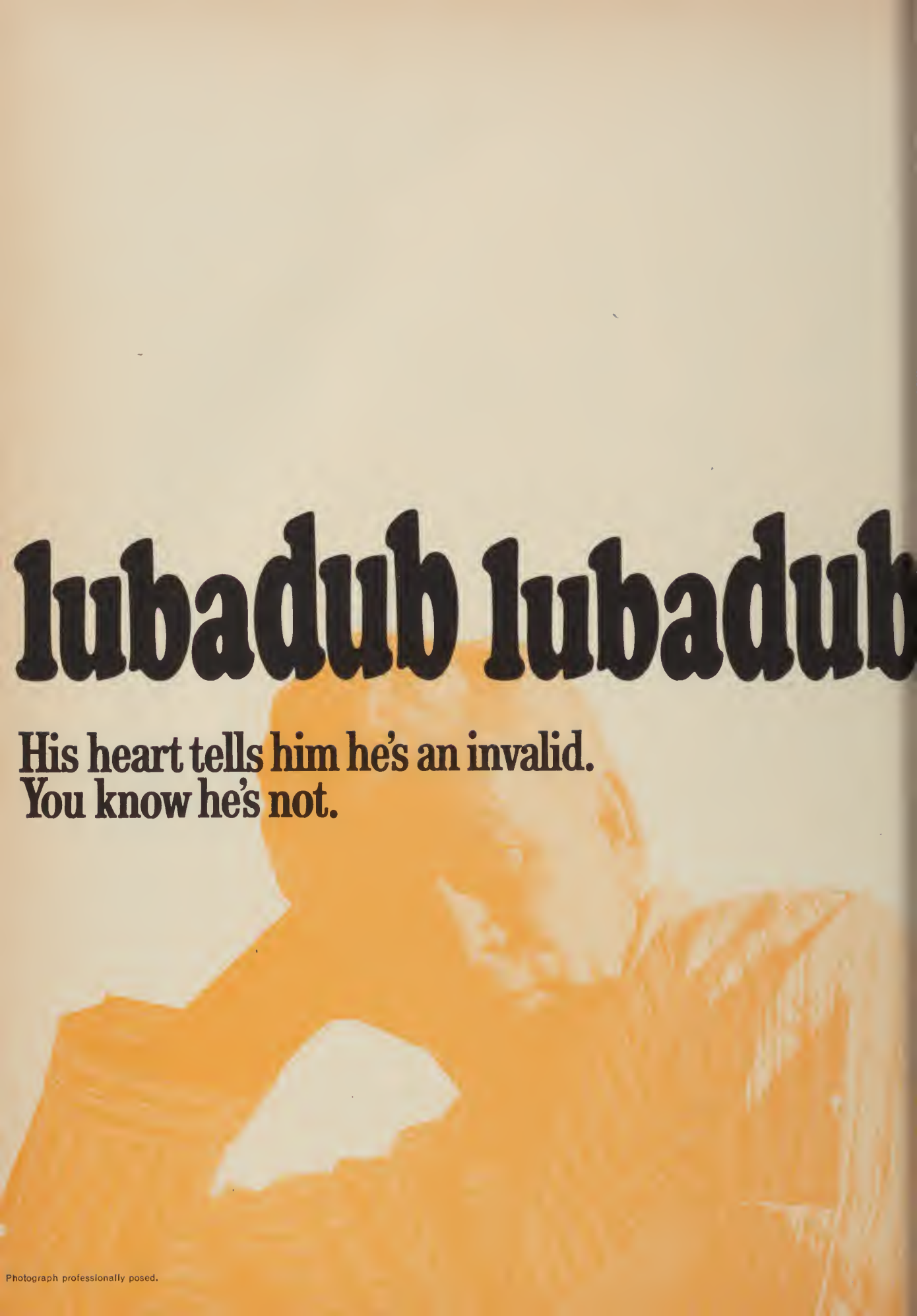
Medical and Chirurgical Faculty of the State of Maryland
1211 Cathedral Street, Baltimore, Maryland 21201
(301) 539-0872

Department of Continuing Medical Education
State Department of Health, 301 W. Preston Street
Baltimore, Maryland 21201, (301) 383-3010 Ext. 8722


"coughing is not a harmless privilege"—Current Therapy 1967, ed. by Conn, H. F., P. 88—
if cough serves no useful purpose
℞ Tussionex®
(Resin complexes of Hydrocodone and Phenyltoloxamine)
...it works (usually for 10 to 12 hours*)
TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.
Class B narcotic — oral Rx where state laws permit.
INDICATIONS: Coughs associated with respiratory infections including chronic sinusitis, colds, influenza, bronchitis, and cough resulting from measles, pulmonary tuberculosis, bronchiectasis, and bronchogenic carcinoma.
*DOSAGE: *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours. *Children:* Under 1 year: 1/4 teaspoonful every 12 hours. From 1-5 years: 1/2 teaspoonful every 12 hours. Over 5 years: 1 teaspoonful every 12 hours.
SIDE EFFECTS: May include mild constipation, nausea, facial pruritus, or drowsiness.
For complete detailed information, refer to package insert or official brochure.
Strasenburgh
Strasenburgh Laboratories Division
Wallace & Tiernan Inc., Rochester, N.Y. 14623

lubadub lubadub

His heart tells him he's an invalid.
You know he's not.



Photograph professionally posed.

Contraindications: History of sensitivity to meprobamate.

Important Precautions: Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use has been reported to result in dependence or habituation in susceptible persons, as alcoholics, ex-addicts, and other severe psychoneurotics. After prolonged excessive dosage, reduce dosage gradually to avoid possibly severe withdrawal reactions. Abrupt discontinuance of excessive doses has sometimes resulted in epileptiform seizures.

Warn patients of possible reduced alcohol tolerance, with resultant slowing of reaction time and impairment of judgment and coordination.

Reduce dose if drowsiness, ataxia or visual disturbance occurs; if persistent, patients should not operate vehicles or dangerous machinery.

Side Effects include drowsiness, usually transient; if persistent and associated with ataxia, usually responds to dose reduction; occasionally concomitant CNS stimulants (amphetamine, mephentermine sulfate) are desirable. Allergic or idiosyncratic reactions are rare, but such reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses who have had no previous contact with meprobamate. Previous history of allergy may or may not be related to incidence of reactions. Mild reactions are characterized by itchy urticarial or erythematous maculopapular rash, generalized or confined to groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. One fatal case of bullous dermatitis following intermittent use of meprobamate with prednisolone has been reported. If allergic reaction occurs, meprobamate should be stopped and not reinstituted. Severe reactions, observed very rarely, include angioneurotic edema, bronchial spasms, fever, fainting spells, hypotensive crises (1 fatal case), anaphylaxis,

bdubdub lubadu

nety is expected in the cardiovascular patient.
lile may even be desirable.

utvhen anxiety is exaggerated . . . when it
teeres with sleep . . . when it aggravates
arovascular symptoms, your help may
e eeded.

atrally, you'll want to reassure the patient.

noperhaps prescribe Equanil (meprobamate)
s djunctive therapy. It helps relieve anxiety
ndension specifically, yet gently.

lmst 15 years' use has shown that Equanil
uually well tolerated as well as effective.
d effects are generally limited to transient
rosiness; serious, therapy-interrupting
deeffects are rare.

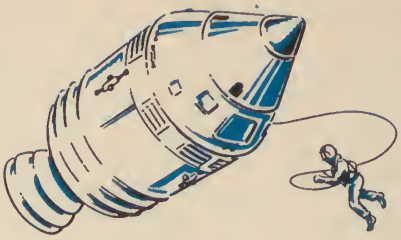
stomatitis and proctitis (1 case) and hyperthermia. Treat symptomatically as with epinephrine, antihistamine and possibly hydrocortisone. Aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis and hemolytic anemia have occurred rarely, almost always in presence of known toxic agents. A few cases of leukopenia, usually transient, have been reported on continuous administration.

Meprobamate may sometimes precipitate grand mal attacks in patients susceptible to both grand and petit mal. Extremely large doses can produce rhythmic fast activity in the cortical pattern. Impairment of accommodation and visual acuity has been reported rarely. After excessive dosage for weeks or months, withdraw gradually (1 or 2 weeks) to avoid recurrence of pretreatment symptoms (insomnia, severe anxiety, anorexia). Abrupt discontinuance of excessive doses has sometimes resulted in vomiting, ataxia, tremors, muscle twitching and epileptiform seizures. Prescribe very cautiously and in small amounts for patients with suicidal tendencies. Suicidal attempts have resulted in coma, shock, vasomotor and respiratory collapse and anuria. Excessive doses have resulted in prompt sleep; reduction of blood pressure, pulse and respiratory rates to basal levels; and occasionally hyperventilation. Treat with immediate gastric lavage and appropriate symptomatic therapy. (CNS stimulants and pressor amines as indicated.) Doses above 2400 mg./day are not recommended.

Composition: Tablets, 200 mg. and 400 mg. meprobamate. Coated Tablets, WYSEALS® EQUANIL (meprobamate) 400 mg. (All tablets also available in REDIPAK® [strip pack], Wyeth.) Continuous-Release Capsules, EQUANIL L-A (meprobamate) 400 mg.

Wyeth Laboratories Philadelphia, Pa.

Equanil®
(meprobamate) Wyeth®



Man in space, now fait accompli, re-emphasizes the importance of Uro-Phosphate therapy. Research into the effect of space travel on the astronaut reveals that weightlessness causes loss of bone calcium. As the bones are required to bear less and less of the weight of the body they lose calcium, increasing the calcium content of the urine. When physical activity is reduced, the acidity of the urine should be adjusted to keep increased calcium in solution . . . . a prophylaxis to prevent kidney or bladder calculi.

Uro-Phosphate®

NOW A SUGAR-COATED TABLET

Each tablet contains: METHENAMINE, *300 mg.;* SODIUM ACID PHOSPHATE, *500 mg.*

Uro-Phosphate gives comfort and protection when inactivity causes discomfort in the urinary function. It keeps calcium in solution, preventing calculi; it maintains clear, acid, sterile urine; it encourages complete voiding and lessens frequency when residual urine is present.

Uro-Phosphate contains sodium acid phosphate, a natural urinary acidifier. This component is fortified with methenamine which is inert until it reaches the acid urinary bladder. In this environment it releases a mild antiseptic keeping the urine sterile.

Uro-Phosphate is safe for continuous use. There are no contra-indications other than acidosis. It can be given in sufficient amount to keep the urine clear, acid and sterile. A heavy sugar coating protects its potency.

Dosage:

For protection of the inactive patient 1 or 2 tablets every 4 to 6 hours is usually sufficient to keep the urine clear, acid and sterile.

2 tablets on retiring will keep residual urine acid and sterile, contributing to comfort and rest.

A clinical supply will be sent to physicians and hospitals on request.

WILLIAM P. POYTHRESS & COMPANY, INC., RICHMOND, VIRGINIA 23217

Manufacturers of Ethical Pharmaceuticals



A Service of the Tuberculosis Association of Maryland

tuberculosis

Toward Control of Viral Infections of Man

Of the available approaches to the control of infections due to viruses, the greatest advances have been made in the development of vaccines, but other avenues are also open. Progress to date, and problems yet to be overcome, are reviewed.

There are today three possible approaches to the control of infection caused by viruses: immunologic (vaccines), host resistance (interferon), and chemical (drugs).

The most effective and economically efficient control procedure attempted to date is specific immunization by vaccines from either live or killed viruses. The latter may be made with adjuvants which enhance the immune response. Human immune globulins are of limited usefulness in the control of viral infections.

A brief review of some of the developments toward protection against viral infection follows:

Smallpox vaccine has been the foundation for the vaccination concept. With gradual improvement in its quality and purity, today this vaccine is bacteriologically sterile and its potency is preserved by drying.

The second viral vaccine to be developed was against rabies. Until recently it was a crude preparation, but propagation of the virus in cell cultures has made possible the production of highly purified killed-virus and attenuated live-virus vaccines for experimental use.

MAURICE R. HILLEMAN, PHD *Science* (Vol. 164, No. 3879), May 2, 1969.

The yellow fever virus is the only one of 230 arboviruses that has yielded satisfactorily to vaccine control.

Influenza A & B in the early 1940's were the first of the respiratory virus vaccines. Influenza vaccine may effect a reduction in illness of 75% to 90% or more. However, a near-total antigenic alteration tends to occur in influenza A virus about every ten years and renders the previous vaccine useless. An urgent need is for a vaccine that provides protection against a number of viral strains.

The live-virus approach against respiratory syncytial virus has been explored, but to date attenuation of the virus has been inadequate.

Polio Vaccines

Reduction of poliomyelitis to insignificant levels in many countries speaks for the effectiveness of both live- and killed-virus vaccines. Live vaccine has many advantages, but low effectiveness has been reported in some tropical areas where improved living conditions have delayed the child's first experience with the virus to an older age than formerly. Continuing infection of the enteric tract with a multiplicity of indigenous enteroviruses may interfere with vaccination by preventing growth of the vaccine strains.

Work on vaccines for the three myxovirus infections of childhood—measles, mumps, and rubella—is in progress. Extensive and proper administration of vaccines against these diseases should result in their near elimination from the United States within a few years.

With the availability of new viral vaccines and the expectation of others in the near future, methods must be developed to simplify administration and to reduce costs.

The use of adjuvants should make it possible to achieve a greater and longer-lasting immunity with a smaller antigenic mass and fewer doses than with aqueous material.

Host Resistance

For more than three decades it has been known that infection with one virus may limit or exclude infection with a second, unrelated virus. This is called the interference phenomenon, which has been shown to be mediated by a protein of low molecular weight, called interferon. It is produced by virus-infected cells and protects new and uninfected cells from viral infection. Thus, interferon, rather than the conventional antibody immune mechanisms, may be responsible for recovery from viral infections in its early stages.

Though active to some degree in experimental tests, interferon prepared in cells outside the body has not achieved practical importance. The alternative approach is use of a safe and effective substance to stimulate the body to produce and distribute its own endogenous interferon. No substance so far tried has as yet proved satisfactory.

Recent research has led to the discovery that certain double-stranded ribonucleic acids are highly active in inducing interferon and host resistance both in animals and in cells in culture. Possibly the presence of a form of viral ribonucleic acid provides an "alert" or "alarm" reaction in the cell, causing it to make interferon.

The possibility of using interferon inducers in human and animal medicine is being actively explored. The interferon mechanism, with its broad spectrum of antiviral activity, gives hope for eventual prophylactic control of those viral infections in which the number of serotypes is too great to control by vaccines. An example is the common cold.

Intensive search for chemical substances for preventing or treating viral diseases have not thus far been rewarding. Vaccines and interferon are prophylactic and do little to aid the cell once it is infected. At present the best hope for the cure of viral infection seems to rest on the chemical approach.

Research in viral chemotherapy has not yet achieved the status of an exact science, hence random screening as well as rational approaches will probably continue to be used. Studies may not be limited to compounds which are nontoxic for cells; rather, the specific antiviral and anticellular activities of a number of substances may be defined in the hope that this may lead to synthesis of nontoxic antiviral compounds on a rational basis.

Team Play Needed

The development of any measure for the control of viral disease, whether it be by immunological, chemical, or host-resistance procedure, is necessarily a slow and painstaking process for which a sophisticated technology must be evolved and a large body of information accumulated. The over-all achievement requires the cooperative team play of a wide variety of disciplines, including at least the fields of virology, cell biology, biochemistry, biophysics, pathology, clinical medicine, epidemiology, and applied biology, and, of course, a large outlay of funds.

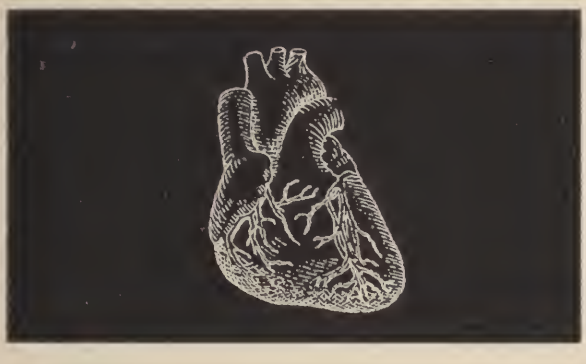
It is possible that viruses may play a role in the vast majority of the illnesses of mankind. The degree to which viral vaccines may prevent such illnesses remains to be seen. Meantime, it seems possible that widespread use of existing and yet-to-be-developed vaccines may eliminate, or reduce, the future incidence of illnesses in which a viral role is not even suspect at present.



MITCHELL'S
MARYLAND
CORN!
Garden Flavor Guarded
F. O. Mitchell & Bro., Inc.
Perryman, Maryland
Phone Perryman 272-3636
Plant Phone
Perryman 272-3637

Baltimore's most unusual dining place!
Famous
Owl Room

Belvedere Hotel
Charles & Chase Streets



JOHN J. MESSINA, MD, EDITOR

A Service of the Heart Association of Maryland

the heart page

Part 1:

The Electrocardiogram in Clinical Alterations of Potassium Homeostasis

RALPH WEBER, MD
Baltimore

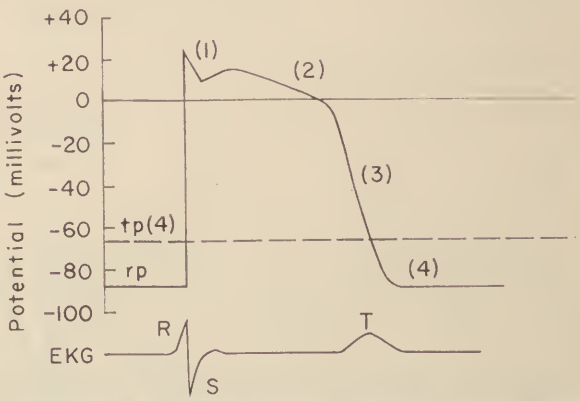
The electrocardiogram (EKG) has generally been more readily available than the flame photometer in the assessment of altered clinical states of potassium (K^+) homeostasis. EKG changes are thought to be a reflection of the sum total of a number of ionic influences at the level of the myocardial cell membrane. Because of this fact, the EKG has often been a more accurate index as to how serious a threat to life altered [K^+] may be than actual chemical determinations of serum K^+ levels. Numerous clinical and experimental observations reveal that the EKG changes of variations in [K^+] can be reproduced or corrected by altering the extracellular [K^+] with a rapidity that seems to exclude intracellular [K^+] as a factor of primary importance. The normal ratio of intracellular to extracellular K^+ is about 30:1. This transmembrane ratio or "gradient" is frequently altered during clinical states associated with changes in the EKG. However, the intracellular myocardial [K^+] is relatively stable under a variety of experimental conditions so that it seems reasonable to conclude that the extracellular [K^+] is the major determinant of the potassium gradient across the myocardial cell membrane.

Potassium intoxication and depletion are more precise terms than hyper- and hypokalemia since alterations attributable to a given clinical state are discussed rather than an isolated serum potassium value. Discussion of the EKG within this clinical framework will not include a variety of experimentally induced preparations or less common artificially induced states (as hemodialysis with fluid containing insufficient K^+) but will be limited to the two designated clinical states as commonly encountered in practice. In general, depletion is usually of a relatively gradual onset (except in familial periodic paralysis), and is much more common than intoxication, although the electrocardiographic changes are much less dramatic. Depletion results from excessive elimination or inadequate intake, conditions associated with abnormal potassium transfer, or combinations of these factors, and most often occurs in association with diuretic therapy. Intoxication is associated with rather striking electrocardiographic changes and almost always occurs in association with transient or permanent renal impairment, from excess administration or formation of potassium (both of which may be of sudden onset as with acute hemolysis in mismatched blood transfusions, crush syndrome, CCl_4 poisoning) decreased renal excretion or combination of these factors. Both intoxication and depletion may be seen during the treatment

of diabetic acidosis (where a large total body potassium deficit is present). When a patient is acidotic and dehydrated, serum K^+ is increased and the EKG suggests K^+ intoxication. During therapy with fluids and insulin, serum K^+ decreases and the EKG suggests K^+ depletion. The EKG sequence of K^+ depletion supervening upon K^+ intoxication has also been observed when a brisk diuresis has followed a period of renal shutdown.

Some general consideration of the relationship between the transmembrane potential (so called monophasic action potential, MAP) of non-specialized myocardial fibers and the surface EKG is useful. According to Hodgkin's ionic theory the membrane permeability to K^+ (and to a lesser extent, Na^+) are the major determinants in this action potential (MAP). MAP is generally divided into several phases (Fig. 1). Phase 0 denotes the rapid upstroke which is thought due to altered permeability of the cell membrane to Na^+ and associated with rapid influx of Na^+ into the cell. Repolarization begins promptly with a short spike designated as phase 1. Phase 2 denotes the slow plateau—like part of repolarization and the plateau configuration is attributed to the interaction of membrane permeability to both Na^+ and K^+ so that little actual electrical potential change occurs. Phase 3 is a more rapid stage of a repolarization which occurs as the membrane becomes more permeable to K^+ with an associated rapid efflux of K^+ from the cell. Phase 4 is the "recovery" phase during which Na^+ (which had previously entered the cell) leaves and K^+ returns. A unique property of specialized cardiac tissue (possessing automaticity) is the occurrence of spontaneous slow "diastolic depolarization" during this period of "electrical diastole." In general, phases 0-1 correspond roughly to the QRS of the surface EKG, phase 2 corresponds to the ST segment and phase 3 to the T wave of the surface EKG. The early portion of phase 4 corresponds to the U wave (probably largely resulting from repolarization of Purkinje fibers).

In observed clinical states of altered K balance, EKG changes of greatest diagnostic significance are generally first discernible on those portions of the tracing inscribed during repolarization (ST and T associated with phases 2, 3 of MAP) and, especially with depletion, phase 4 (MAP). If the configuration and duration of the QRS remains unchanged alterations in the ST and T segments are generally considered "primary." In general, alterations in the QRS are evident in association with more severe $[K^+]$ derangements and are more dependent on less well understood factors such as conduction velocity. Conduction velocity also varies in different locations of the heart. Although variation in extracellular K^+ affects all cardiac cells in the same general direction, a differential sensitivity exists in various types of cardiac tissues. Certain specialized cardiac fibers (i.e., SA node, some specialized atrial internodal conduction paths, N - H region of AV nodal tissue and Bundle of His) are more resistant to changes in K^+ than others (Purkinje fibers). Within the non-specialized cardiac tissue (muscle fibers) ventricular myocardium appears more resistant to $[K^+]$ than atrial myocardial fibers.



Relationship of transmembrane potential (above) and EKG (below). (after Hoffman and Cranefield)

References available upon request

Visit the #1 Spot for Your Diet Needs

Now in our new location

1 No. Howard St.

(Corner of Baltimore St.)

For the Food Your Doctor Advises

● Low Sodium ● Sugar-free ● Non-allergic

SPECIAL DIET SHOP

Phone SA 7-0383

WE PRESCRIBE FOR DOCTORS:

Invest your money where it will earn a high return in complete safety

CAPITAL SAVINGS AND LOAN ASSOCIATION

INCORPORATED 1907

421 NORTH CHARLES STREET

CORNER FRANKLIN STREET

BALTIMORE, MARYLAND 21201

PHONE 752-6000

BYLAWS COMMITTEE

Semiannual Meeting, September 1969

Mr. President and Members of the House of Delegates:

The Bylaws Committee met on Wednesday, June 18, 1969, to consider the recommitment of a proposed bylaw amendment, together with a pending amendment at the time of recommitment. The proposed amendment and the pending amendment read as follows:

Substitute for Article IV, Section 3, the following new section which reads as follows:

Section 3. One-third of the COUNCILORS provided below shall be elected annually by the House of Delegates from among the active members of component societies comprising the following districts:

(a) Western District: Allegany, Garrett, Carroll, Frederick and Washington Counties
(b) Eastern District: Caroline, Cecil, Dorchester, Kent, Queen Anne's, Somerset, Talbot, Wicomico and Worcester Counties.
(c) Central District: Baltimore City, Baltimore and Harford Counties
(d) Southern District: Anne Arundel, Calvert, Charles, Howard and St. Mary's Counties
(e) South Central District: Montgomery and Prince Georges Counties

Representation shall be on the basis of one Councilor from each district, plus one additional councilor for each 200 active and 40 year members in good standing on December 31 of each year.

*A COMPONENT SOCIETY IN THE CENTRAL AND SOUTH CENTRAL DISTRICTS SHALL BE ENTITLED TO BE REPRESENTED ON THE COUNCIL AS NEARLY AS MAY BE POSSIBLE BY ONE COUNCILOR FOR EACH 200 ACTIVE AND 40 YEAR MEMBERS IN GOOD STANDING OF SUCH COMPONENT SOCIETY ON DECEMBER 31 OF EACH YEAR.

*Pending amendment at time of referral.

All members of the Bylaws Committee were present for this meeting, consisting of Arthur E. Cocco, MD, Dewitt E. DeLawter, MD, Vincent J. Fiocco, Jr., MD, and Charles F. O'Donnell, MD, Chairman. Also present were Mr. Thomas Young, office of the Faculty's legal counsel; Mr. William J. Evans, Faculty Parliamentarian; and Mr. John Sargeant, Executive Secretary.

Discussion centered around the advisability of approving the proposed, pending amendment and whether or not this would restrict unduly the actions of the House of Delegates in the free election of Councilors to represent and act on behalf of the House during the interim between sessions of the House of Delegates.

It was determined that acceptance of the proposed pending amendment would do just this, and in addition, would be extremely difficult to administer because of nominations from the floor which are now accepted on the basis of district representation.

It was also felt that the House of Delegates could be trusted to exercise its discretion in ensuring that adequate representation of the components in each district is provided; and that the fears expressed at the Annual Session of the House of Delegates were unduly exaggerated.

The Bylaws Committee recommends that the pending amendment proposed on behalf of the Baltimore City Society be rejected and that the proposed Bylaw amendment be adopted with the following amendments:

(1) Amend the first paragraph after the word "active" by inserting the words "and 40 year members".
(2) Amend the final paragraph after "200" and before the word "Active", by inserting "or major fraction thereof".
(3) Amend the final paragraph before the words "December 31" by inserting "the preceding".

The Bylaws Committee presents the following additional Bylaw amendments for consideration of the House of Delegates:

Amend Article IV, Section 1, by striking out the figures "22"

OLD (Brackets indicate deletion)	*NEW* (Underlined portion additions)
Section 1. THE ELECTIVE OFFICERS shall be a President, a President-elect, a First, Second and Third Vice-President, a Secretary, a Treasurer and (22) Councilors.	Section 1. THE ELECTIVE OFFICERS shall be a President a President-elect, a First, Second and Third Vice-President, a Secretary, a Treasurer and Councilors.

AS OF DECEMBER 31, 1968

CENTRAL DISTRICT	NO. OF MEMBERS	TOTAL	COUNCIL MEMBERSHIP Present	Proposed
Baltimore City	1,558			
Baltimore County	287			
Harford County	51	1,896	11	11
EASTERN DISTRICT				
Caroline County	7			
Cecil County	23			
Dorchester County	19			
Kent County	13			
Queen Anne's County	4			
Somerset County	7			
Talbot County	37			
Wicomico County	75			
Worcester County	7	192	2	2

SOUTH CENTRAL DISTRICT				
Montgomery County	516			
Prince Georges County	212	728	5	5
SOUTHERN DISTRICT				
Anne Arundel County	120			
Calvert County	7			
Charles County	10			
Howard County	18			
St. Mary's County	18	173	2	2
WESTERN DISTRICT				
Allegany County	86			
Carroll County	47			
Frederick County	62			
Garrett County	5			
Washington County	94	294	2	2

The Bylaws Committee also considered other matters at this meeting.

Throughout the Bylaws in Article XI—Committees, reference is made to members of the Baltimore City Dental Society serving on various Faculty committees. The Bylaws Committee has some reservations as to the advisability of their serving on some of these committees; and also questions whether or not such representatives should not be referred to as representing the Maryland State Dental Society.

The Council has been asked to name a special group to confer with the dental societies and discuss this further. Any proposed amendments will be considered at a later date and offered to the House of Delegates at an appropriate time.

The Bylaws Committee also carefully evaluated the various charges to Committees in the same Article XI. It has the following recommendations to make:

Amend Article XI, Section 11, by inserting the words, "and formulate guidelines" after the word "complaints."

OLD

(Brackets indicate deletion)

Section 11. *A MEDIATION COMMITTEE* composed of the five most recent living Immediate Past Presidents, not serving on the Commission on Medical Discipline and at least five additional members appointed by the President shall hear and determine all grievances or complaints involving or growing out of the practice of medicine as provided by these bylaws and mediate all problems involving or growing out of the practice of medicine. The chairman shall be appointed by the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote in all committee deliberations except those relating to grievances or complaints.

NEW

(Underlined portion additions)

Section 11. *A MEDIATION COMMITTEE* composed of the five most recent living Immediate Past Presidents, not serving on the Commission on Medical Discipline and at least five additional members appointed by the President shall hear and determine all grievances or complaints and formulate guidelines involving or growing out of the practice of medicine as provided by these bylaws and mediate all problems involving or growing out of the practice of medicine. The chairman shall be appointed by the President. The Baltimore City Dental Society shall have the right to elect one associate member of the committee with voice but without vote in all committee deliberations except those relating to grievances or complaints.

Amend Article XI, Section 14, by adding an additional sentence which reads as follows:

"The tenure of office for this Committee shall be for one year and shall commence at a time that is mutually agreeable with the Maryland State Bar Association, so as to ensure that individual members shall serve conjointly with their respective counterpart members."

OLD

(Brackets indicate deletion)

Section 14. *A MEDICOLEGAL COMMITTEE* shall join with the corresponding committee of the Maryland State Bar Association, composed of an equal number, for the consideration of problems common to, or of concern to, both the medical and legal professions. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.

NEW

(Underlined portion additions)

Section 14. *A MEDICOLEGAL COMMITTEE* shall join with the corresponding committee of the Maryland State Bar Association, composed of an equal number, for the consideration of problems common to, or of concern to, both the medical and legal professions. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President. The tenure of office for this Committee shall be for one year and shall commence at a time that is mutually agreeable with the Maryland State Bar Association, so as to ensure that individual members shall serve conjointly with their respective counterpart members.

Amend Article XI, Section 15 by striking out the entire section.

OLD

(Brackets indicate deletion)

(Section 15. The President shall appoint *A MEMBERSHIP COMMITTEE* of at least three active and at least two associate members which shall consider the rights and classes of membership; make recommendations to the component societies regarding methods of recruiting new members, and arrange memorials or tributes to deceased members. The President shall designate the chairman.)

NEW

(Underlined portion additions)

NONE

Amend Article XI, Section 17, by substituting a proposed new section which reads as follows:

Section 17. *AN OCCUPATIONAL AND ENVIRONMENTAL HEALTH COMMITTEE* of at least five members shall study and report as it deems advisable upon occupational and environmental health matters. It shall consider such subjects as occupational health problems in industry; consumer protection matters such as food, drugs, etc.; hazardous substances, such as poisons, toys, devices, etc.; the quality of the health environment such as water and air pollution and land use, etc.; as well as traffic safety, such as warning devices, highway signs, automobile construction, accident evacuation, first aid training, etc.

Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the president.

OLD

(Brackets indicate deletion)

(Section 17. *AN OCCUPATIONAL HEALTH COMMITTEE* of at least five members shall study and report as it deems advisable upon occupational disease programs and health programs in industry. Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.)

NEW

(Underlined portion additions)

Section 17. *AN OCCUPATIONAL HEALTH COMMITTEE* of at least five members shall study and report as it deems advisable upon occupational and environmental health matters. It shall consider such subjects as occupational health problems in industry; consumer protection matters such as food, drugs, etc.; hazardous substances, such as poisons, toys, devices, etc.; the quality of the health environment such as water and air pollution and land use, etc.; as well as traffic safety, such as warning devices, highway signs, automobile construction, accident evacuation, first aid training, etc.

Its chairman shall be appointed by the President and said chairman shall appoint the other members of the committee with the approval of the President.

Respectfully submitted,

ARTHUR E. COCCO, MD
DEWITT E. DELAWTER, MD
VINCENT J. FIOCCO, JR., MD
CHARLES F. O'DONNELL, MD, *Chairman*



Insurance For The Doctor

PROFESSIONAL LIABILITY*

Workmen's Compensation
Equipment Floater
Bonds on Employees
Public Liability
Fire Insurance
Disability Income
Term Life Insurance
Pension Plans

* *Endorsed by MEDICAL SOCIETY OF D. C. & MD.*

Russell, Marsh & Kennedy, Inc.

5151 WISCONSIN AVE. WASHINGTON, D. C. 20016 244-7600

Delegates to the AMA House of Delegates
Annual Session, New York City,
July 13 through 17, 1969

Mr. President and Members of the House of Delegates:

The Faculty's three delegates and alternates attended the 1969 annual meeting of the AMA's House of Delegates. Business considered at this session included 59 reports from the AMA Board of Trustees, the Executive Vice-President and standing and special committees of the AMA House. In addition, over 130 resolutions of major and minor importance were presented for consideration.

As is usual, all items of business were referred to various Reference Committees presenting an opportunity for individual AMA members and others to present their viewpoints on the subjects under consideration. Each of the delegates and alternates was assigned to a reference committee hearing and a cross exchange of information and summaries of the discussions taking place at these open meetings enabled the voting delegates to better understand and reach a decision on the Reference Committee reports presented to the House of Delegates for action.

The House heard comments from the Vice-President of the United States, Spiro T. Agnew, and also from the new Assistant Secretary of Health, Education and Welfare of the United States, who is assigned to Health and Scientific Affairs activity. Roger O. Egeberg, MD, was received cordially by the House and commented briefly on the health care system in the United States.

Following is a summary of the actions of the House of Delegates in capsule form. Full details may be obtained from the Faculty office, or from any of the Faculty's Delegates to the AMA House.

AMA Membership for Osteopaths

In response to a House directive at the Clinical Convention, 1968, that qualified osteopaths be admitted to full active membership in the AMA, the House amended the first paragraph of Chapter I, Section 1 of the Bylaws as follows:

> (A) Regular Members—Regular membership shall be limited to those members of a state medical association who hold the degree of Doctor of Medicine or Bachelor of Medicine, or who hold an unrestricted license to practice medicine and surgery, and are entitled to exercise the rights of membership in their state medical associations, including the right to vote and hold office, as determined by their state medical associations.

This was in response to the resolution introduced at the 1968 Clinical session by Maryland's delegation, calling for such a Bylaw change.

Scientific Sections

The Ad Hoc Committee to Study the Modus Operandi of the Scientific Sections reported its belief (which the House adopted) that the AMA can achieve greater unity within the medical profession and further strengthen its scientific program by inviting the national medical specialty societies to play a more active and responsible role and giving those societies a privilege of participating in the selection of section delegates in the AMA House and other section officers.

The scientific assembly will be divided into these specialty sections:

Allergy
Anesthesiology
Clinical Pharmacology and Therapeutics (formerly Experimental Medicine and Therapeutics)
Colon and Rectal Surgery
Dermatology
Diseases of the Chest
Family and General Practice (formerly General Practice)
Gastroenterology
General Surgery
Internal Medicine
Military Medicine
Obstetrics and Gynecology
Ophthalmology
Orthopedic Surgery
Otorhinolaryngology
Pathology (formerly Pathology and Physiology)
Pediatrics
Physical Medicine and Rehabilitation (formerly Physical Medicine)
Preventive Medicine
Psychiatry and Neurology (formerly Nervous and Mental Diseases)
Radiology
Special Topics
Urology

AMA Bylaws, Chapter VII, Sections 3-9, are to be rewritten to effect these changes, among others.

Each section will establish a section council. After the 1970 Clinical Convention, medical specialty societies will be invited to help form section councils.

Membership of the section councils "shall be selected by the national specialty societies listed in the American Medical Directory apportioned on the basis of the number of AMA members belonging to each specialty society and one member to be elected by the scientific section from the section membership."

At the 1971 Annual Convention, establishment of AMA section councils will be reported to each specialty section. The councils become effective January 1, 1972.

All section councils will be under the direction of the Board of Trustees and will be governed by rules established by the Board and approved by the House.

Reference Committee A

Cost of Care

The House stated that "The physician's influence on the costs of health care will be in proportion to his conscious efforts to adhere to practices which conserve the resources of his patient. As the provider of medical service, the doctor has a significant and responsible role in any organized effort to control health care expenditures. In this role, the physician has a challenge to maintain and improve a system that best serves the public and is most acceptable to him and to the profession of which he is a part."

Medicare and Medicaid

In connection with reducing medicaid costs, the House adopted a report listing four action programs of the profession: *expanded peer review programs* by county medical societies to reduce hospital and nursing home care and to *expand ambulatory care; eradication* by the profession of *isolated abuses* by physicians; promotion of innovative health service delivery systems for low income communities, with *emphasis on ambulatory care;* and

programs by local medical societies to *preserve quality of care* in the face of cost containment measures.

With respect to physician payment in teaching situations, the House resolved that the Board of Trustees "take action to evaluate and effect *improvement of the regulations in keeping* with the intent of Medicare and Medicaid in relation *to teaching situations.*"

On the subject of medicare fees and fee schedules, the House said, "While the AMA has not taken a specific position on the procedures relating to the development and application of physicians' fees profiles and prevailing charge screens, the actions which have been taken by the House would indicate that these concepts as defined through directives of the Social Security Administration, are not consistent with policies of the American Medical Association."

The House also said that since "Actions taken by DHEW to set rigid limits on levels of payments to physicians who provide services under Medicaid appear in contradiction to Congressional intent that Medicaid patients receive care on the same basis as private patients," it resolved that the AMA "urge a re-assessment by Congress of its intent and priorities in relation to Title XIX."

Regarding the isolated abuses of government programs, the House resolved that the Board's "efforts to obtain access to information referable to alleged misuse of any programs of health care be commended" but added that "In the *publicizing of charges* without the availability of reasonable and specific facts concerning individuals, the result is detrimental to the best interests of American medicine."

Voluntary Health Insurance

The House adopted a report urging that state medical associations, county societies and physicians individually direct "unstinting effort" to promote the proposed program of income tax credits for financing health care and "publicize the advantages inherent in this approach to preserve and strengthen the voluntary system."

Delegates also resolved that the AMA "encourages the development of prepayment medical insurance programs in which the *payment* to the physician is *based upon the usual, customary or reasonable fee concept*" and that "any reference to 'paid-in-full' coverage clearly identify those services which are indeed covered on a 'paid-in-full' basis and also identify the circumstances under which those services must be rendered."

Billing Procedures

"To ensure the continuance of the one-to-one physician-patient relationship," the House stated, "the profession considers direct billing preferable—identifying Medicare primarily as a financial aid to the patient. As long as Medicare holds to a realistic assessment of 'reasonable charges,' there will be comparatively few instances when direct billing entails greater out-of-pocket payment by the patient than does assignment."

Peer Review

This statement was adopted by the House: "The Council on Medical Service knows of no greater challenge facing the profession today than to secure universal acceptance and application of the (peer) review concept as the most meaningful method for creating a public awareness of medicine's efforts to assure high quality of health services at a reasonable cost."

Comprehensive Health Planning

The House said, about comprehensive health planning, that "Certainly, physicians and their professional organizations must accept the responsibility of working in the planning group throughout all stages of planning in order to provide guidance in choosing goals and programs that will realistically meet the community's needs;" and further resolved that "financial reimbursement for health care be based on the adequacy, competency and efficiency of patient care and not on the basis of approval by any regional planning agency."

Reference Committee B

Medical Care as a Right

To make its position clear in the long-standing discussions of medical care as a right, the House resolved that it "reaffirm its position (1) that it is a basic right of every citizen to have available to him adequate health care; (2) that it is a basic right of every citizen to have a free choice of physician and institution in the obtaining of medical care; and (3) that the medical profession, using all means at its disposal, should endeavor to make good medical care available to each person."

Government Reports

The House resolved that "the American Medical Association make every effort to secure appropriate payment to physicians for complex and detailed reports prepared for use by governmental agencies." This resolution does not affect the 1965 Judicial Council opinion that simplified insurance forms be completed without charge.

Extended Care

Because of the higher cost of hospitalization, the House resolved that the AMA "be urged to seek changes in the medicare law *to allow direct admission* to extended care facilities when eligible patients' conditions require less than acute hospital care."

Reducing Paper Work

Recognizing the avalanche of paper that threatens to inundate physicians, the House resolved that the AMA and state medical associations "undertake new discussions with governmental agencies, insurance companies and hospitals with the objective of achieving substantial reductions in the amount of paper work—hopefully amounting to at least a one-half decrease—and thus reducing the cost of health care and enabling physicians to devote the maximum time and effort possible to the care of patients."

Reference Committee C

Private Practice

A resolution that the AMA "establish a Council on Private Practice, with the primary objective being to espouse the aspirations and goals of private practice" was adopted by the House and referred to an ad hoc committee to be appointed by the Speaker of the House.

Federal Support of Medical Schools

In a change of House policy regarding federal loans to medical students, a joint report of the Board of Trustees and the Council on Medical Education was approved which calls for an increase in financial support of medical schools by the federal government to permit a major increase in the enrollment of medical students and the production of physicians. The change was considered justified because of current fiscal conditions which make it increasingly difficult for students to obtain loans from the private sector as a result of high interest rates and a restricted supply of money for personal loans.

Relicensure

The House approved a report recommending that "the physician's continued competency to provide quality health services be maintained by every practical means available; that a relicensure program not be considered at this time; that peer group evaluation be continually utilized and improved; that methods of improving the availability and the content of continuing education programs be continually investigated and refined; that additional incentives be positive in nature and come from within the profession."

Educational "Essentials"

The House approved essentials of an accredited educational program in nuclear medical technology; revision of essentials of approved residencies in thoracic surgery, neurology, anesthesiology and general requirements, revision of essentials of approved internship to provide for participation of osteopaths; revision of essentials of approved residencies pertaining to osteopaths; and essentials of an accredited educational program for medical assistants.

Reference Committee D

Health Care of the Poor

The House adopted the report of the Board of Trustees' Committee on Health Care of the Poor, which reiterated "our strong commitment toward expanding nationwide programs to improve the health of the poor" and stated that "the same quality of medical care should be accessible to all people."

The committee listed "certain concepts that we believe must be included in the Association's program:" (Paraphrased and condensed.)

1. Providing comprehensive health care to the poor is a desirable goal.
2. It must be a continuing program, identifying both short-range and long-range activities.
3. The committee's purpose must be to implement the research that has been done on unmet needs for health services.
4. Program must provide for participation of the poor in planning projects for their communities.
5. Physicians should work with numerous other organizations, both in and out of the health field, that have expressed concern about improving health care of the poor.

The committee concluded by stating that it "recognizes that the problems for which it hopes to find solutions are too critical and too complex for superficial, cursory answers. It believes that dynamic action in this field must have a top priority in the American Medical Association's activities."

Physicians and Hospitals

Most items considered by this Reference Committee had to do with physicians, hospitals and the JCAH.

For example, the House resolved that "the AMA Commissioners to the JCAH urge the Joint Commission to insure that that body which carries out the governing function of *the medical staff shall be representative of the medical staff, both hospital-based and voluntary,* and that this body shall advise the governing board of the hospital on policy regarding medical judgment and skill and on matters relating to the bylaws, rules and regulations of the medical staff."

The House also resolved that the AMA urge the JCAH "to give approval to effective staff and section meeting structures *which combine two or more hospitals* with overlapping medical staffs within a logical geographical area."

Reference Committee E

Full Disclosure of Laboratory Billing

The House adopted a Judicial Council report, "Review of Ethical Considerations Relating to Clinical Laboratories," which ended with this paragraph: "Where it is necessary for the attending physician to bill his patient for services performed by a clinical laboratory, the bill submitted by the attending physician to his patient should state the name of the clinical laboratory performing the services for his patient and state the exact amount of the laboratory charge paid or to be paid by the physician to the clinical laboratory."

Also adopted was the resolution that the "attending physician is entitled to fair compensation for the professional services he renders. He is not engaged in a commercial enterprise, however, and any markup, commission or profit on the services rendered by a laboratory is exploitation of the patient."

Blood Donors

The House encouraged "state medical associations to actively promote state legislation to provide that persons age 18 or over may donate blood without the necessity of parental permission or authorization and without restriction to voluntary or non-compensatory blood donation programs."

Prescription Labeling

Two resolutions concerning the labeling of prescriptions were referred to the Board of Trustees and the Council on Legislative Activities, after being adopted by the House. One recommends legislation requiring labeling; the other encourages labeling.

Reference Committee F

Financial Report

The AMA's financial statement for the year ending June 30, 1969, was approved and the House then resolved that "the Finance Committee of the Board of Trustees meet in advance of each Annual Convention with the Reference Committee to which the annual Financial Statement will be referred for presentation and discussion of more detailed budget and financial data of the Association, so that the Reference Committee will be able to make a more meaningful evaluation for the House of Delegates."

AMA Management Survey

The House adopted the management survey report of Cresap, McCormick and Paget and approved the analysis of communications made by the Philip Lesly Company.

In connection with the former, the House approved the Reference Committee's list of eight subjects to which "the highest priorities in activities and programs should be assigned:"

1. The rising cost of health care.
2. The expansion of out-of-hospital health services.
3. The development of community health centers.
4. Experimentation and innovation on new methods of delivery of health services.
5. Medical audit, utilization and review committees.
6. Medical manpower needs.
7. Preventive medicine.
8. Family planning.

The House also requested that the Board of Trustees (1) develop program priorities; (2) outline specific techniques of resolving the problems caused by those priority programs; and (3) report to the House at each semi-annual session on progress being made.

State Projects of AMA

The House resolved that "financial support by the AMA for local or area health service projects should be preceded by consultation with the constituent association of the state or states in which the projects are to be conducted."

Professional Liability

In connection with professional liability, the House adopted the following statements as recommendations of the AMA:

1. First, that constituent associations "seek the enactment of appropriate state legislation designed to provide a more efficient and equitable determination of malpractice claims and litigation."
2. Second, that state associations, with the help of AMA, "seek the cooperation of hospital associations and third party payers in exploring and developing, if feasible, pilot programs which will provide scheduled benefits for persons injured as a consequence of medical accidents occurring in the delivery of health care, irrespective of fault."
3. Third, "that workshops on malpractice insurance problems be conducted, as requested by the Board of Trustees, in which participation will be invited from (1) physicians confronted by insurance problems, (2) representatives of the insurance carriers, (3) staff attorneys of AMA and other appropriate staff personnel, (4) representatives of and attorneys for the hospital service field, (5) nurses and (6) legislators."

In addition, the House resolved that the AMA "should not attempt to establish a nationwide professional liability insurance program either by sponsorship of a program underwritten by an existing insurance carrier or by seeking to establish a new insurance carrier."

Reference Committee G

Sex Education

While recognizing "that the primary responsibility for family life education is in the home," the House supported "in principle the inauguration by State Boards of Education or school districts, whichever is applicable, of a voluntary family life and sex education program at appropriate grade levels:

"(1) as part of an overall health education program;
"(2) presented in a manner commensurate with the maturation level of the students;
"(3) following a professionally developed curriculum foreviewed by representative parents;
"(4) including ample and continuing involvement of parents and other concerned members of the community;
"(5) developed around a system of values defined and delineated by representatives comprising physicians, educators, and clergy and other appropriate groups; and
"(6) utilizing classroom teachers and other professionals who have an aptitude for working with young people and who have received special training."

Nursing

The House reaffirmed "its support of all forms of nursing education including baccalaureate, diploma, associate and practical nurse education programs" and encouraged "the continuation of federal, state and local subsidies to schools of nursing education."

Smoking and Health

The House resolved that the AMA "again urge its members to play a *major role against cigarette smoking by personal example* and by advice regarding the health hazards of smoking" and "discourage smoking by means of public pronouncements and educational programs." It also resolved to "indicate to the Congress of the United States the incongruity of the expenditure of tax dollars to promote the production and sale of tobacco while at the same time spending other tax dollars to discourage cigarette smoking because of its hazard to health."

Food Mixes

The House requested the U.S. Food and Drug Administration to "favorably consider the proposal of the Council on Foods and Nutrition regarding labeling of fatty-acid composition" of food mixes, and that the Council on Foods and Nutrition "undertake the development of a rational proposal for identifying and labeling other nutritionally significant components of convenience foods."

Protective Headgear

The Committee on the Medical Aspects of Sports was asked by the House "to continue its efforts to utilize and publicize existing research and recommendations on football helmets to assure optimum protection for players against impacts which cause head and neck injuries" and "to do everything possible to discourage the practice of 'spearing.' "

Reference Committee H

Highway Signs

A Board of Trustees report and a resolution were adopted recommending a uniform system of highway directional signs designating emergency medical facilities. However, the House pointed out clearly that "this action does not encourage or approve the use of the copyrighted AMA symbol for other unauthorized and unidentified programs."

Credit Cards

Two resolutions concerning the use of credit cards to pay for medical care were referred to the Judicial Council for information, "with the expectation that additional opinions will be rendered as experience accumulates." In certain states, the Reference Committee pointed out, a charge card system is under experimentation by the state medical society and is deserving of a chance to prove its merits. Also, the Judicial Council has ruled that the use of a charge card system should be flexible and at the discretion of the individual state medical societies.

Medical Instruments and Devices

Pointing out that legislation related to federal standards to regulate the use of medical instruments and devices was introduced in the 90th and 91st congresses, the House resolved that the AMA "be commended for its position supporting the concept of a thorough study of the field of medical instruments and devices prior to passage of specific regulatory legislation."

Unification Through AMA

The House resolved that the Board of Trustees be

asked to begin a study "of physicians who are not members of the AMA, and then make recommendations to the House of Delegates and to the State and County Societies, as to how the medical profession may more wisely unify itself under the AMA banner, and encourage non-participating physicians to join."

Presentations, Awards and Announcements

Robert E. Gross, MD, was presented the Dr. Rodman E. Sheen and Thomas G. Sheen Award. Dr. Gross is Ladd Professor of Children's Surgery at Harvard Medical School and director of cardiovascular surgery at Children's Hospital Medical Center, Boston.

Charles A. Berry, MD, medical director of the NASA Manned Spacecraft Center in Houston, was presented a plaque: "The American Medical Association presents this citation for distinguished service to Charles A. Berry, MD, and the medical staff of the Manned Spacecraft Center, NASA, at Houston, Texas, in recognition of their efforts in solving the difficult and complex problems of assuring the health and contributing substantially to the safety and survival of the astronauts participating in the United States space exploration program."

Stephan R. Chernay, MD, New York, received the first AMA recognition award for continuing education.

Executive Vice President E. B. Howard announced to the House the appointment of Richard Wilbur, MD, Calif., as Assistant Executive Vice President of the AMA. An Assistant Executive Vice President for Scientific Affairs also is to be named.

The medical winners in the 20th International Science Fair for high school students were introduced to the House and their exhibits were included among the scientific exhibits at the convention.

They were Cathy Jennemann, 16, a junior at Monte Cassino High School, Tulsa, Okla., whose exhibit was "Possible Deafness From Everyday Noise;" and Greg Kauffman, 16, a junior at Albuquerque (N.M.) High School, "Pyelonephritic Recurrence."

Student American Medical Association

Your Delegates met with and were interviewed by James Smith of the Univeristy of Maryland School of Medicine, and Charles Avery of the Johns Hopkins University School of Medicine who were in attendance during the AMA meeting. They were spending the summer on a grant supported by the U.S. Department of Health, Education and Welfare and the Office of Economic Opportunity, and investigating all aspects of the field of medicine other than scientific; i.e., socioeconomic, etc. Following the AMA meeting, both of these individuals will be working in a preceptorship with a United States Senator or Congressman, newspaper, or some other public activity.

Questions asked by these students were searching and pertinent. One had the feeling that "pat" answers were not blandly accepted. The Delegates were struck with an increased social awareness in the medical students of today which was not present in our era. The interviews were mutually stimulating and made one slightly uncomfortable in realizing that "stock" replies were often inadequate.

Interruption

The House suffered a 21-minute interruption during its opening session Sunday when 30 to 40 dissident medical students and their friends, seized the podium and demanded the right to address the House.

The news release they distributed identified them as representatives of the Student Health Organization, the Medical Committee for Human Rights, the Movement for a Democratic Society, the Health Policy Advisory Center, the Rockefeller University Committee for a Democratic Society "and many others."

The group's spokesman began by declaring the meeting "illegal and illegitimate" and ended by burning what he called his AMA membership card, but which television news described as a Blue Shield card.

He came back Wednesday with a "non-negotiable demand" for 10 minutes to speak during the inaugural ceremony, but was flatly refused by the Reference Committee on Rules and Order of Business.

Robert vL. Campbell, MD
J. Sheldon Eastland, MD
Russell S. Fisher, MD
Charles F. O'Donnell, MD, Senior Alternate

DOCTOR'S SUITE AVAILABLE

Well-established Professional Building, centrally located in the Northwood Shopping Center.

Two inner offices and reception area, common waiting room, Telephone Service and Free Parking.

PROFESSIONAL BUILDING

Northwood Shopping Center
Argonne Drive and Loch Raven Blvd.
BALTIMORE, MARYLAND 21218
Phone LE 9-5210

- ART SERVICES
- COMPOSITION
- OFFSET & LETTERPRESS
- ROTARY
- FLEXOGRAPHIC
- PAMPHLET & BOOKBINDING
- MAILING

THE EVANGELICAL PRESS
THIRD & REILY STREETS
HARRISBURG, PA. 17102
PHONE (717) 233-6411

"Making Good Impressions Through Good Impressions"



DOUGLAS G. CARROLL, MD, EDITOR

rehabilitation notes

The Effect of Urinary Diversion on Urinary Tract Disease in Patients with Spinal Cord Injury

FRANCIS J. BORGES, MD
Director, Department of Medicine
Montebello State Hospital
Associate Professor of Medicine
University of Maryland School of Medicine

ALAN Z. STEINBERG *
Junior Medical Student
University of Maryland School of Medicine

** Supported by the Maryland State Department of Health Summer Medical Student Program in Public Health, Project #1206.*

PAULO P. MENDONCA, MD
Research Associate in Surgery
Division of Urology
University of Maryland School of Medicine

Presented at the 16th Annual Medical and Dental Students Seminar of the Maryland State Department of Health, August 13, 1968.

Patients with traumatic injury to the spinal cord experience unique illnesses not commonly seen in the average medical-surgical community. The greatest causes of morbidity and mortality among these patients are renal failure, cardiovascular, pneumonia, cerebrovascular disorders, suicide, and gastrointestinal problems, in that order.[1] Of these problems, renal failure or genitourinary sepsis are by far the most common causes of death.[1, 2] Recent studies indicate that the average length of life in the quadriplegic-paraplegic is 20 years.[1] This average longevity has not appreciably improved between the years 1960 to 1967, nor has there been a significant reduction of renal failure as a cause of death during that time.[1, 2] Because of the prevalence of renal failure as a cause of death, it seems proper to evaluate those efforts directed toward maintaining renal function in these patients. Avoidance of obstruction to urinary flow and elimination of foreign body in the urinary tract are the cardinal principles involved in the prevention of urinary tract infection. Diversion of the urinary stream by means of the ileal loop is currently in vogue as a measure toward maintaining the aforementioned principles. It is the purpose of this study to evaluate the role of the ileal loop in preventing urinary tract infection and deterioration of renal function.

Procedure

From April 27, 1953 to December 31, 1967, 447 patients with quadriplegia or paraplegia secondary to spinal cord trauma were hospitalized at Montebello State Hospital, Baltimore, Maryland. During this time 44 (10%) patients have undergone a urinary diversion procedure, usually ileal loop, as described by Bormel and Galleher.[3] These patients are divided into three groups: 13 patients currently hospitalized, 20 discharged, and 11 patients who are deceased.

The patients considered in this study are the 13 currently hospitalized. This report is limited to this group because these patients have been under direct surveillance by one of us (F.J.B.) for two years, and because chronic hospitalization affords accurate observations as recorded on the patients' charts.

The data were compiled by a review and interview of the patient and his chart. In 9 of 13 instances the patient's hospitalization came under our surveillance for the entire course following their initial injury. All patients have had chronic hospitalization with the usual preliminary work up and serial intravenous pyelograms, cystograms, cystometrograms, urinalysis and urine cultures.

The incidence of urinary tract infection (UTI) was tabulated by using an infection-time ratio. This ratio was calculated by computing the number of infections per time in months and multiplying by 100 to eliminate fractions. The ratio was used to indicate the infection rate, and to eliminate differences in length of time of hospital course.

The following four questions were asked in an attempt to define the role of the ileal loop in preventing urinary tract morbidity and mortality:

1. **What were the indications for performing the ileal loop?**
2. **Were the indicated objectives achieved by the procedure?**
3. **Was the frequency of urinary tract infection altered?**
4. **What was the effect of this procedure on morbidity and longevity?**

Results

Table I describes the patients comprising this study. Of the total 13 patients, nine are men and four are women. At the time of their injury the average age was 30 years (with a range from 16 to 48). At the time of the ileal loop procedure, the average age was 34 years (range 16-57). The average length of follow-up, post ileal loop, was 29 months (range 4-96). There were nine quadriplegics and four paraplegics in this group. Eleven of the patients experienced spinal cord trauma, and two patients had their paralysis secondary to infectious polyneuronitis. Only one patient (A.B.) had a documented history of lower urinary tract infection prior to spinal cord injury.

Table II presents the indications for ileal loop listed by patient. Four patients—F.W., J.W., J.P., A.B.—had the ileal loop performed for chronic fistula; three men with a urethro-cutaneous fistula at the penile-scrotal junction (PSJ), and one woman patient with a urethro-vaginal fistula. Only one patient (A.B.) of these four also had accompanying radiologic changes suggestive of pyelonephritis. In another sub-group of four patients—M.R., J.H., J.D., E.H.—the primary indication for diversion was vesico-ureteral reflux (V-U), either bilateral or uni-

TABLE I

Vital Statistics of the Study Group

Patient	Sex Race	Type & Location of Injury	Age at Injury (Yrs.)	Age at Operation (Yrs.)	Post-op Follow-up (Mos.)
1. F.W.	WM	Fx-Dx C5-C6 Quad	20	20	20
2. J.W.	WM	Fx-Dx C8 Quad	48	51	4
3. J.P.	WM	Fx-Dx C5-C6 Quad	25	28	14
4. A.B.	NF	Fx-Dx C5 Quad	36	37	23
5. M.R.	WF	Trans Myel. Quad	26	31	56
6. J.H.	NF	Fx-Dx T8-T9 Para	20	21	12
7. J.D.	NM	Fx-Dx C6 Quad	50	52	37
8. E.H.	NM	Fx-Dx L1 Para	41	51	13
9. D.T.	WM	Fx-Dx C5-C6 Quad	16	16	10
10. L.G.	NM	Fx-Dx T7-T8 Para	31	32	26
11. D.B.	NM	Fx-Dx C5-C6 Quad	35	41	36
12. A.C.	NM	Fx-Dx C5-C6 Quad	32	35	29
13. J.L.	WF	Trans Myel. Para C6-C8	17	23	96
			—	—	—
		Mean	30	34	29
		Range	(16-48)	(16-57)	(4-96)

TABLE II

Indications for Ileal Loop

Patient	Primary Indication	Secondary Indication	Radiographic Evidence of Pyelonephritis
1. F.W.	PSJ* Fistula	Recurrent UTI	None
2. J.W.	PSJ* Fistula	Recurrent UTI	None
3. J.P.	PSJ* Fistula	Hydronephrosis, Rt.	None
4. A.B.	Urethro-Vaginal Fistula	Recurrent UTI	Present
5. M.R.	V-U reflux	Bilateral caliectasis	None
6. J.H.	V-U reflux (unilat)	Ureterocele	Present
7. J.D.	V-U reflux	Hydronephrosis, Bilat. Uremic acidosis	Present
8. E.H.	V-U reflux	Urethral diverticulum	Present
9. D.T.	Recurrent UTI	Septicemia	None
10. L.G.	Recurrent UTI	Bilateral caliectasis Dilated ureters	Present
11. D.B.	Recurrent UTI	Staghorn calculus	
12. A.C.	Recurrent UTI	Hypertonic bladder	Present
13. J.L.	Left chronic pyelo Patulous urethra	Hydroureters	Present Present

** PSJ = Penile-Scrotal Junction*

lateral. Three out of four in this group had changes indicative of pyelonephritis (caliectasis, blunting, forniceal rounding) in addition to the V-U reflux. A third sub-group of four patients—D.T., L.G., D.B., A.C.—underwent urinary diversion for persistent urinary tract infection. In this group, three of the four patients also had evidence of pyelonephritis. Patient J.L. received an ileal loop because of patulous urethra, spastic bladder, and evidence of chronic pyelonephritis in her left kidney.

Table III indicates the infection-time ratio for both the pre- and post-urinary diversion periods. In 12 of 13 patients the incidence of urinary tract infection was reduced. There was a mean decrease in the infection-time ratio from 59 (range 11-300) in the pre-diversion period to 7 (0-33) in the post-loop follow up period. In one instance the infection-time ratio increased from 5 to 11, however this particular patient could not be evaluated accurately due to the presence of two cutaneous ulcers during two separate febrile episodes with pyuria. Although fever and pyuria responded to urinary tract antibiotics, cutaneous ulcers may have caused a febrile response, and may have responded to antibiotics.

TABLE III

Pre- and Postoperative Infection-Time Ratio

Patient	Pre Op.	Post Op.
1. F.W.	300	33
2. J.W.	14	0
3. J.P.	19	17
4. A.B.	33	0
5. M.R.	80	0
6. J.H.	44	0
7. J.D.	46	17
8. E.H.	11	4
9. D.T.	25	0
10. L.G.	100	19
11. D.B.	13	11
13. J.L.	17	4
Mean	59	7
Range	(11-300)	(33-0)
12. A.C.	5	11

The status of the urinary tract post-urinary diversion is shown in Table IV. The sub-group whose primary indication was V-U reflux could not be evaluated as to improvement, since the anatomy of the loop is such that free reflux usually occurs on ileogram. The remaining nine patients showed improvement of their primary indication for surgery.

The postoperative course was further evaluated on the basis of radiographic evidence of pyelonephritis and bladder complications. One patient, L.G., was not evaluated since no postoperative intravenous pyelograms were available. Of the 12 remaining patients, seven showed no change or improvement in the radiologic changes and five had evidence that this disease process had progressed. Nine of the 13 patients had their bladders remaining after construction of the ileal loop. Six of these nine patients subsequently developed pseudomonas bladder empyema during their postoperative course. The remaining three patients had sterile bladder excretions.

Summary

During its 15 years of service to the State of Maryland, 447 patients with spinal cord injury were hospitalized at Montebello State Hospital. Forty-four of these patients have undergone a urinary diversion procedure, usually ileal loop. This investigation was undertaken to answer the following four questions concerning the effectiveness of the ileal loop urinary diversion in altering urinary tract disease:

1. What were the indications for performing the ileal loop?
2. Were the indicated objectives achieved by the procedure?
3. Was the frequency of urinary tract infection altered?
4. What was the effect of this procedure on morbidity and longevity?

TABLE IV

Status Post Ileal Loop Procedure

Sub-Group	Primary Indication			Evidence of Pyelonephritis			Bladder Complications
	*NC	I	P	NC	I	P	
FISTULA		F.W.		F.W.			**pseudom. blad. empy.
		J.W.		J.W.			bladder clear
		J.P.		J.P.			cystectomy
		A.B.			A.B.		pseudom. blad. empy.
VESICO-URETERAL REFLUX		Not Evaluated		M.R.			**pseudom. blad. empy.
						J.H.	cystectomy
						J.D.	pseudom. blad. empy.
						E.H.	cystectomy
RECURRENT URINARY TRACT INFECTION		D.T.		D.T.			**pseudom. blad. empy.
		L.G.		Not Evaluated			cystectomy
		D.B.				D.B.	bladder clear
		A.C.			A.C.		bladder clear
J.L.		J.L.				J.L.	**pseudom. blad. empy.

* Key: NC—No Change
I —Improved
P —Progressed

**pseudom.—pseudomonas
blad. —bladder
empy. —empyema

The group studied was limited to 13 patients currently hospitalized. Four patients in this group underwent an ileal loop diversion for the presence of a draining cutaneous fistula in the lower urinary tract, a second group of 4 patients had their operation to eliminate vesico-ureteral reflux, and a third group of 4 patients experienced recurrent episodes of urinary tract infection as the chief indication for diversion. The 13th patient had an ileal loop done because of a patulous urethra, spastic bladder and unilateral chronic pyelonephritis.

The results indicate that ileal loop diversion did serve as an effective remedy for the chief urinary tract problem in nine of nine (100%) patients evaluated. The remaining four patients could not be adequately evaluated since the main indication for diversion was the presence of vesico-ureteral reflux.

The frequency of urinary tract infection was effectively reduced in 12 of 13 patients. This was a mean reduction of urinary tract infection to one seventh of the pre-ileal loop diversion incidence. The radiographic evidence of pyelonephritis was either improved or remained stationary in 58% of the patients.

The authors waived evaluation of the effect on longevity until the whole group of 44 patients who received the ileal loop can be studied.

These results indicate that an ileal loop is effective in suppressing or improving urinary tract complications in selected paraplegic-quadriplegic patients.

REFERENCES

1. Jousse, A. T.; Wynne-Jones, Megan; and Breithaupt, D. J.: A Follow-up Study of Life Expectancy and Mortality in Traumatic Transverse Myelitis, *Canad M J*, **98:** 770, 1968.
2. Hackler, R. H.; Dalton, J. J., Jr.; and Bunts, R. C.: Changing Concepts in the Preservation of Renal Function in the Paraplegic, *J Urol*, **94:** 107, 1964.
3. Bormel, P. and Galleher, Earl, Jr.: Reversed Peristalsis and Other Complications of Ureteroileostomies, *J Urol* **88:** 203, 1962.

We wish to extend recognition and appreciation to John D. Young, Jr., MD, Professor of Urology, University of Maryland School of Medicine, and to his staff who performed the surgery on the majority of these patients, and for their assistance and guidance in conducting this study.

STERLING LIGHTING CO.



DISTINCTIVE
LIGHTING FIXTURES
OF BEAUTY

We Repair and make Lamps
"Lamps make the home Beautiful"

LE 9-0222 403 N. Charles Street
Baltimore, Md. 21201

CAMP, CHARIS, KELLOGG
CORSET SHOP
Dorothy P. Barnes
ORTHOPEDIC, SURGICAL & MATERNITY GARMENTS
PRESCRIPTIONS FILLED PROMPTLY
BRACES & SURGICAL SUPPLIES
BRAS, GIRDLES
PERSONAL FITTINGS BY APPOINTMENT
Over 23 years experience
2318 N. Charles St. 467-8441
If no answer, call 448-4004
Baltimore, Md. 21218



heavenly relief
for unearthly cough

Benylin®
EXPECTORANT

Each fluidounce contains: 80 mg. Benadryl® (diphenhydramine hydrochloride, Parke-Davis); 12 grains ammonium chloride; 5 grains sodium citrate; 2 grains chloroform; 1/10 grain menthol; and 5% alcohol.

An antitussive and expectorant for control of coughs due to colds or of allergic origin, BENYLIN EXPECTORANT is the leading cough preparation of its kind. BENYLIN EXPECTORANT tends to inhibit cough reflex... soothes irritated throat membranes. And its not-too-sweet, pleasant raspberry flavor makes BENYLIN EXPECTORANT easy to take.

PRECAUTIONS: Persons who have become drowsy on this or other antihistamine-containing drugs, or whose tolerance is not known, should not drive vehicles or engage in other activities requiring keen response while using this preparation. Hypnotics, sedatives, or tranquilizers if used with BENYLIN EXPECTORANT should be prescribed with caution because of possible additive effect. Diphenhydramine has an atropine-like action which should be considered when prescribing BENYLIN EXPECTORANT.

ADVERSE REACTIONS: Side reactions may affect the nervous, gastrointestinal, and cardiovascular systems. Drowsiness, dizziness, dryness of the mouth, nausea, nervousness, palpitation, and blurring of vision have been reported. Allergic reactions may occur.

PACKAGING: Bottles of 4 oz., 16 oz., and 1 gal.

Parke, Davis & Company
Detroit, Michigan 48232

PARKE-DAVIS

410R69



Appearances may be deceiving



It may be tetracycline

but it's not ACHROMYCIN® V
Tetracycline HCl

unless it bears this signature.



250 mg. and 100 mg. capsules

Contraindications: Hypersensitivity to tetracyclines.
Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.
Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: Gastrointestinal—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.

Lederle

LEDERLE LABORATORIES
A Division of American Cyanamid Company
Pearl River, New York 10965

530-9



symptoms of mixed anxiety-depression are rarely clear-cut..
but they are often a clear indication for

Mellaril®
(thioridazine)
25 mg. t.i.d.

effective in mixed anxiety-depression and in moderate to severe anxiety

Before prescribing or administering, see Sandoz literature for full product information, including adverse reactions reported with phenothiazines. The following is a brief precautionary statement.

Contraindications: Severe central nervous system depression, comatose states from any cause, hypertensive or hypotensive heart disease of extreme degree.

Warnings: Administer cautiously to patients who have previously exhibited a hypersensitivity reaction (e.g., blood dyscrasias, jaundice) to phenothiazines. Phenothiazines are capable of potentiating central nervous system depressants (e.g., anesthetics, opiates, alcohol, etc.) as well as atropine and phosphorus insecticides. During pregnancy, administer only when necessary.

Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

Adverse Reactions: *Central Nervous System*—Drowsiness, especially with large doses, early in treatment; infrequently, pseudoparkinsonism and other extrapyramidal symptoms; nocturnal confusion, hyperactivity, lethargy, psychotic reactions, restlessness, and headache. *Autonomic Nervous System*—Dryness of mouth, blurred vision, constipation, nausea, vomiting, diarrhea, nasal stuffiness, and pallor. *Endocrine System*—Galactorrhea, breast engorgement, amenorrhea, inhibition of ejaculation, and peripheral edema. *Skin*—Dermatitis and skin eruptions of the urticarial type, photosensitivity. *Cardiovascular System*—Changes in the terminal portion of the electrocardiogram have been observed in some patients receiving the phenothiazine tranquilizers, including Mellaril (thioridazine). While there is no evidence at present that these changes are in any way precursors of any significant disturbance of cardiac rhythm, several sudden and unexpected deaths apparently due to cardiac arrest have occurred in patients previously showing electrocardiographic changes. The use of periodic electrocardiograms has been proposed but would appear to be of questionable value as a predictive device. *Other*—A single case described as parotid swelling.

SANDOZ PHARMACEUTICALS, HANOVER, N.J. SANDOZ 69 384

MAKE ANY DAY

"Special"

with

BLOOMING BEAUTY

• We Grow Our Flowers •



We Also Make
Artificial Arrangements

F.T.D.

Geo. **RADEBAUGH** *& Sons*

120 Burke Ave. Towson, Maryland 21204

Phone VAlley 5-4300

Skilled Hands That Care



Twenty four hours a day . . . in bright, modern facilities, the aged, chronically ill and convalescent, receive professional care, nutritional balanced foods . . . and occupational and recreational therapy programs.

Competent registered nurses see that your instructions are followed exactly.

HOUSE IN THE PINES
NURSING HOMES

Baltimore, Md.
BEL-AIRE—5837 Belair Road.....CL 4-8800
BELVEDERE—2525 W. Belvedere Ave.....FO 7-9100

Catonsville, Md.
CATONSVILLE—16 Fusting Ave.....RI 7-1800

Easton, Md.
EASTON—Rt. 50 & Dutchman's Lane.....TA 2-4000
Your Inspection Invited—Brochure Upon Request

attention doctors--

When you guard the health of your funds by investing them where they are safe and accessible, you're practicing preventive medicine against inflation. And, funds grow at a gratifying rate through DAILY compounding of dividends.

5.23%
ON PASSBOOK ACCOUNTS
Effective Annual Yield
Compounded & Computed
DAILY

Guaranteed Protection
Accounts insured up to $20,000 by the Maryland Savings Share Insurance Corp.

SECURITY
Savings & Loan
(a stock corporation) Organized 1895
Downtown—24 E. Fayette St.
Branch—Security Shopping Center

MARYLAND SAVINGS SHARE INSURANCE CORPORATION INSURED YOUR SAVINGS INSURED UP TO $20,000

RUG CLEANING
Of the Highest Quality at Reasonable Prices
ORIENTAL & DOMESTIC
- Repairing
- Storing
- Installing
- Moth-proofing

Expert Oriental Rug Repairing & Reweaving
SPECIALISTS IN CLEANING WALL-TO-WALL CARPETS AND FURNITURE IN YOUR HOME
A large selection of Antique and Modern Oriental Rugs and Carpets Available
EST. 1922
Hanna IMPORTER
HOpkins 7-6600
2015 W. 41st ST.
Baltimore, Md. 21211





Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg.; Dextromethorphan hydrobromide, 7.5 mg.
A. H. Robins Company, Richmond, Virginia 23220
A·H·ROBINS

MR. PHYSICIAN
IT IS MORE ECONOMICAL TO LEASE THAN TO BUY A NEW CAR
Check With Your Accountant, He'll Agree!
- *No insurance charges
- *Full insurance coverage
- *No maintenance problems or costs
- *Replacement car available
- *Select any car you desire from a compact to a deluxe model

From $99.99 per month
BR. 6-5000
1970 Models Available Now
24 Hour Service
Why Pay More?
Why Take Less?
AVON CAR LEASING

Ef-
fic-
iency

Dicarbosil®
ANTACID

Your ulcer patients and others will confirm it. Specify DICARBOSIL 144's—144 tablets in 12 rolls.

ARCH LABORATORIES
319 South Fourth Street, St. Louis, Missouri 63102

Listing of Sources of Short-Term Training for Laboratory Workers

The Laboratory Consultation and Development Section of the National Communicable Disease Center is compiling a list of organizations which offer short-term training for persons working in clinical and public health laboratories. Academic training for full-time students will not be included. When completed, the list will be made available to all individuals interested in continuing education for medical laboratory personnel. The compilation will serve to alert training coordinators, supervisors and prospective students to the existence of many little-known sources of short-term training, some at no cost to the student.

Companies, professional associations, individuals, and schools who desire to furnish information for inclusion in the listing should write:

National Communicable
Disease Center

Attention:

Mr. John H. Krickel
Education Specialist
Laboratory Division
Atlanta, Georgia 30333

No information will be included in the published list without prior clearance from the organization or individual offering the training.

RUN RIGHT TO Read's DRUG STORES

TWO ALL NIGHT DRUG STORES

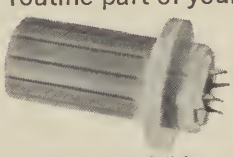
★ INGLESIDE SHOPPING CENTER
5646 BALTIMORE NAT'L. PIKE (Beltway Exit 15)
PHONE: 747-1237

★ HILLENDALE SHOPPING CENTER
6867 LOCH RAVEN BLVD. (Beltway Exit 29)
PHONE: VA 5-8900

Since 1883, the most important phase of *Read's* services has been dispensing prescriptions—Because of this, our 2 *All-Nite* prescription service stores were established so that prescriptions could be filled not only during "waking hours", but also after midnight at these 2 All-Nite drug store locations—with complete drug store service around the clock.

TB is still around.

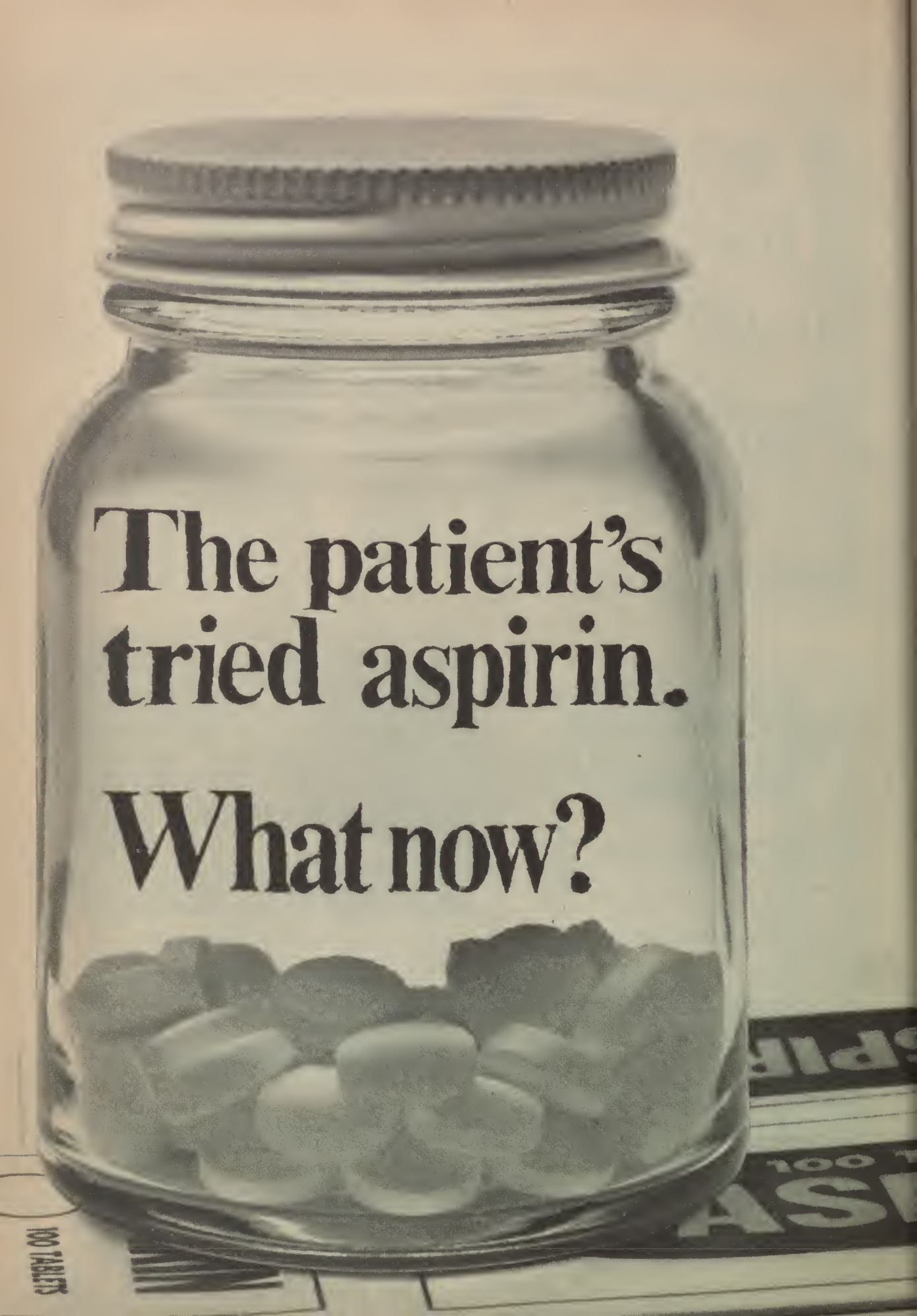
In 1967 almost 45,000 new active cases were reported. Isn't that a good reason to make tuberculin testing with the white LEDERTINE™ Applicator a routine part of your physical examinations?



TUBERCULIN TINE TEST
(Rosenthal) with Old Tuberculin

Precautions: With a positive reaction, consider further diagnostic procedures. Use with caution in persons with active tuberculosis or known allergy to acacia. Vesiculation, ulceration, or necrosis may occur at the test site in highly sensitive persons.

Lederle LEDERLE LABORATORIES
A Division of American Cyanamid Company, Pearl River, N.Y.


The patient's
tried aspirin.
What now?
100 TABLETS

There's a good chance your patient needs more than a non-prescription analgesic for pain relief. Especially after self-medication has failed.

Because continuing, increased pain and discomfort may in part be a reflection of anxiety, Equagesic is worthy of consideration. In a single, non-narcotic preparation, it helps relieve pain . . . *and* associated anxiety and tension.

Tablets

Equagesic®

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

IN BRIEF

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: USE IN PREGNANCY: Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

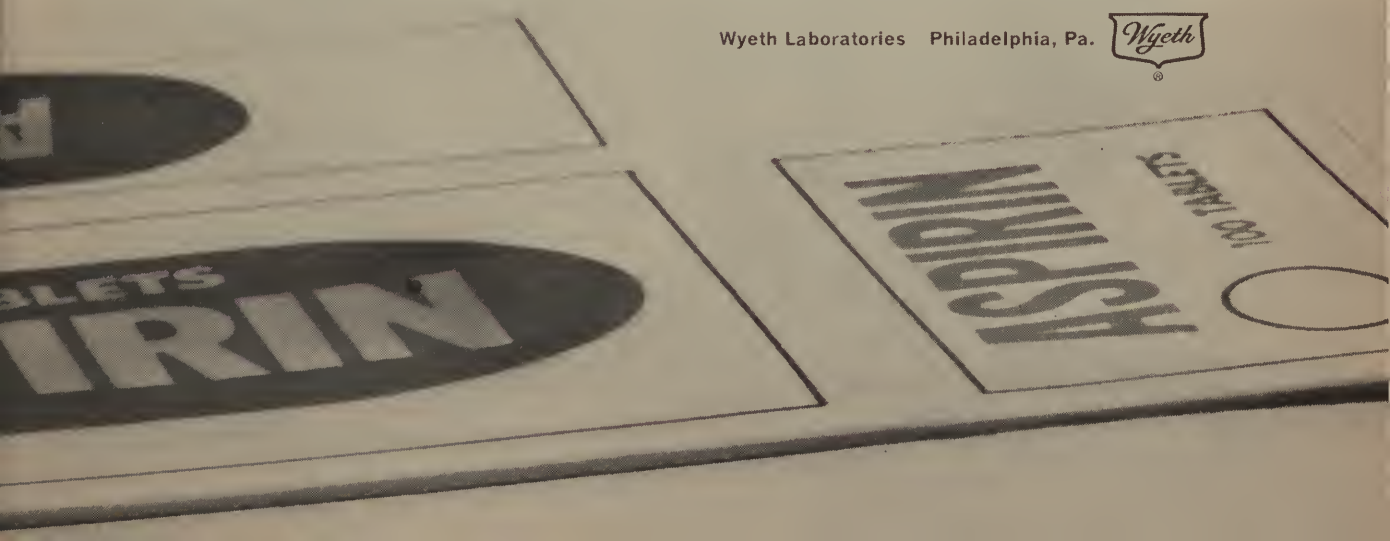
Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa. Wyeth®



SKILL SURGICAL, INC.

SUPPLIES & EQUIPMENT
for
PHYSICIANS—SURGEONS
HOSPITALS

5406 Harford Road Phone 254-2800
BALTIMORE, MD. 21214

MANUEL SCHWARTZ
HEARING REHABILITATION
321 Medical Arts Bldg. Phone: 685-4898
BALTIMORE, MARYLAND 21201
DIAGNOSTIC AUDIOLOGY
PRESCRIPTION PROSTHESIS
HEARING AID EVALUATION
AUDITORY COUNSELING
CUSTOM EAR MOLDS AND
AURAL RECONSTRUCTION
Patients Accepted Upon Medical Referral
Diagnostic Report Sent
To Referring Doctor

TOWSON TELEPHONE SECRETARIES
Mrs. Isabel Flanagan—Owner
WE ANSWER YOUR PHONE
24 HOURS A DAY — EVERY DAY
MONTH - TO - MONTH BASIS
ORDER BY PHONE
"INSURE YOURSELF AGAINST LOSS OF PATIENTS' CALLS"
7112 York Rd. 825-1300
Just below Stevenson Lane TOWSON, MD.

- Photo-Offset Printing
- Multigraphing
- Multilithing
- Addressing & Mailing
- Letterpress Printing
- Monocast Letters
- Mimeographing
- Typing
- Automatically Typewritten Letters

Prompt Pick-up and Delivery MU 5-3232

D. Stuart Webb
Advertising Services, Inc.
306 N. Gay Street Baltimore, Md. 21202

HIGHLAND HOSPITAL

ASHEVILLE, NORTH CAROLINA
Founded 1904

A DIVISION OF THE DEPARTMENT OF PSYCHIATRY OF DUKE UNIVERSITY

Accredited by the Joint Commission on Accreditation and Certified for Medicare

Complete facilities for evaluation and intensive treatment of psychiatric patients, including individual psychotherapy, group therapy, psychodrama, electro-convulsive therapy, Indoklon convulsive therapy, drugs, social services work with families, family therapy, and an extensive and well organized activities program, including occupational therapy, art therapy, music therapy, athletic activities and games, recreational activities and outings. The treatment program of each patient is carefully supervised in order that the therapeutic needs of each patient may be realized.
High school facilities for a limited number of appropriate patients are now available on grounds. The School Program is fully integrated into the hospital treatment program and is accredited through the Asheville School System.
Complete modern facilities with 85 acres of landscaped and wooded grounds in the city of Asheville.

Brochures and information on financial arrangements available

Contact: MRS. ELIZABETH HARKINS, ACSW, *Coordinator of Admissions*
or
CHARLES W. NEVILLE, JR., M.D.
Assistant Professor of Psychiatry and Medical Director
Area Code 704—254-3201

Information for Authors

MANUSCRIPTS: Manuscripts will be accepted for consideration for publication with the understanding that they are original, have never before been published, and are contributed solely to the Maryland State Medical Journal.

All manuscripts are acknowledged upon receipt and are followed up by notification of either acceptance or rejection. Rejected manuscripts are returned by regular mail. Accepted manuscripts become the property of the Journal and are not returned. The Journal is not responsible for loss of manuscripts through circumstances that are beyond its control.

Manuscripts should be addressed to: Editor, Maryland State Medical Journal, 1211 Cathedral St., Baltimore, Md. 21201.

SPECIFICATIONS: Manuscripts must be original typed copy, doublespaced throughout (Including text, case reports, legends, tables and references) with margins of at least 1½ inches. Pages should be numbered consecutively.

The manuscript should include the title (brief and concise), the full name of the author (or authors) with degrees, academic and professional titles, affiliations, and any institutional or other credits. Please include a complete address where the author may receive proofs of his article for his approval and corrections.

All manuscripts should be accompanied by a carbon or Xerox copy and the author should retain another copy for his records.

TABLES: Each table should be typed on a separate sheet of paper, be numbered, have a brief descriptive title, and its position in the text should be indicated.

Be sure that statistics are consistent in both tables and text.

REFERENCES: References should be limited to those citations noted in the text, and kept to a minimum of 18. (A complete review of the literature is rarely desirable.) The references must be typed, doublespaced, and are to be numbered consecutively as they appear in the text, with their positions in the text indicated. An alphabetized bibliography is used only when the listing is of books suggested for supplementary reading.

All references must be checked for absolute accuracy. Each journal reference must include author(s) and initials, complete title of article, name of publication, volume, first page of article, and date. Complete dates (month, day, and year) are to be included with all references that have appeared within the last three years. Include with book references name of author(s) and/or editor(s) with initials, title of book, edition, location, publisher, year, volume (if given), and page. If reference is to a chapter within a book, include the author of the chapter (if different from author of the book), and the title of the chapter, if any.

ILLUSTRATIONS: Authors are urged to use the services of professional illustrators and photographers when possible. Drawings and charts should always be done in black ink on white paper. Clear, glossy photographs, black on white, should be submitted and such illustrations numbered consecutively and their positions indicated in the text.

Magnifications will be modified in proportion to the amount of reduction necessary to fit the pages of the Journal. Please do not deface an illustration by writing on the front or the back, nor should it be taped or pasted to paper. The illustration may be pasted onto a piece of cardboard. Attached to the back of each illustration, chart or photograph should be the figure number, the author's name and the title of the article.

Legends for illustrations should be typewritten on a separate page with numbers corresponding to those on the photographs and drawings.

Recognizable photographs of patients are to be masked and should carry with them written permission for publication.

EDITORIAL RESPONSIBILITY: Manuscripts are subject to editorial modification and such revisions as are necessary to bring them into conformity with Journal style.

Statements made or opinions expressed by any contributor in any article or feature published in the Journal are the sole responsibility of the author.

PERMISSIONS: When material is reproduced from other sources, full credit must be given to both the author and publisher and written permission from these sources must be included when the material is submitted.

COPYRIGHT: Material that is published in the Maryland State Medical Journal is protected by copyright and may not be reproduced without the written permission of both the author and the Journal.

COLOSTOMY
ILEOSTOMY

Appliances and Disposable Bags

CALL
FIELDS PHARMACY
IN PIKESVILLE

for convalescent supplies and service

FOR RAPID DELIVERY **486-3300**

Do Your Patients Need Nursing Service?

Call **889-5666**

COBB-WOODS SERVICES
Vera Woods, M. A. Director

2213 St. Paul St. Baltimore, Md. 21218

Licensed by the State of Md.

FRANKLIN UNIFORM COMPANY

SOUTH'S LARGEST UNIFORM HOUSE

235 PARK AVENUE BALTIMORE, MD. 21201 MU 5-7222



Fashion goes Professional in the new 3 button notched lapel coat. Roomy patch pockets add a touch of dash to the modern, slimming silhouette.

#315—in long sleeves only in 65% Dacron Polyester and 35% Cotton Dac-o-Gab

Sizes 34 to 46

White **$10.99**

Black **$8.99**

- **SIDE GRIPPER**
- **SET IN BACK BELT**

#303—100% Cotton Jean Twill **$3.99**

#400—100% Cotton—2x1 Sanforized Poplin **$4.99**

#801—65 Poly./35 cot. Tricot **$6.99**

#805—100% Dacron Shantung **$6.99**

All men's jackets short sleeves only
Sizes 34 to 46





MEN'S LAB

511—8 oz. Sanf. Duck **$5.99**

5514—Tan. Sanf. Linene **$5.99**

414—Heavy Sanf. Twill **$6.99**

811—100% Dacron Herringbone Twill **$12.99**

Sizes 34-46

WOMAN'S LAB

310—Sanforized Twill Jean **$5.99**

3310—65/35 Dacro-Gab **$9.99**

Sizes 28-40

- **ZIPPER FRONT**
- **SET IN BACK BELT**
- **CONVERTIBLE COLLAR**
- **LARGE PATCH POCKETS**

#304—Short sleeves 80% Polyester, 20% Cotton White, Aqua, Blue **$7.99**

#204—Short sleeves 100% Dacron Polyester Shantung White, Aqua, Blue **$7.99**

100% Cotton Drip Dri Broshan Slub Sanforized Plus White, Aqua, Blue **$4.99**

Sizes 34 to 46



OTHER STORES IN

Washington, D. C. 20001
900—11th St., N.W.
EX. 3-8200

Richmond, Va. 23219
710 E. Grace Street
MI. 4-2685

Norfolk, Va. 23510
123 W. Freemason Street
MA. 7-3639



Nose clear as a whistle

(THANKS TO DIMETAPP®)

Dimetapp Extentabs® does an outstanding job of helping to clear up the stuffiness, drip and congestion of colds and upper respiratory allergies and infections. Each Extentab keeps working up to 12 hours. And for most patients drowsiness or overstimulation is unlikely. Try Dimetapp. It clearly works.

FOR UPPER RESPIRATORY ALLERGIES AND INFECTIONS

Dimetapp Extentabs®

Dimetane® (brompheniramine maleate), 12 mg.; phenylephrine HCl, 15 mg.; phenylpropanolamine HCl, 15 mg.

UP TO 12 HOURS CLEAR BREATHING ON ONE TABLET

Indications: Dimetapp is indicated for symptomatic relief of the allergic manifestations of respiratory illnesses, such as the common cold and bronchial asthma, seasonal allergies, sinusitis, rhinitis, conjunctivitis, and otitis.
Contraindications: Hypersensitivity to antihistamines. Not recommended for use during pregnancy.
Precautions: Until patient's response has been determined, he should be cautioned against engaging in operations requiring alertness. Administer with care to patients with cardiac or peripheral vascular diseases or hypertension.
Side Effects: Hypersensitivity reactions including skin rashes, urticaria, hypotension and thrombocytopenia, have been reported on rare occasions. Drowsiness, lassitude, nausea, giddiness, dryness of the mouth, mydriasis, increased irritability or excitement may be encountered.
Dosage: 1 Extentab morning and evening.
Supplied: Bottles of 100 and 500.

A.H. ROBINS COMPANY
RICHMOND, VA. 23220

A·H·ROBINS



Owner Breaks Arm When Yacht Runs Aground

Schuyler, Oct. 31. Harry Waters of Covesville incurred a fractured arm [illegible] yacht [illegible] ck a large rock tially capsized. The fire departm had to rescue Waters by small b Damage to the yacht is estimate ?.

Hasn't the skipper had enough excitement for one day?

For the patient who has been through an accident, the worry and anxiety following the mishap may actually heighten the perception of pain. This is why there's a classic ¼ grain *sedative* dose of phenobarbital in Phenaphen with Codeine—to take the nervous "edge" off, so the rest of the formula can control the pain more effectively.

A. H. Robins Company, Richmond, Va. 23220 A·H·ROBINS

Phenaphen® with Codeine

Phenaphen with Codeine Nos. 2, 3, or 4 contains: Phenobarbital (¼ gr.), 16.2 mg. (warning: may be habit forming); Aspirin (2½ gr.), 162.0 mg.; Phenacetin (3 gr.), 194.0 mg.; Hyoscyamine sulfate, 0.031 mg.; Codeine Phosphate, ¼ gr. (No. 2), ½ gr. (No. 3), or 1 gr. (No. 4) (warning: may be habit forming).

The compound analgesic that calms instead of caffeinates

Indications: Phenaphen with Codeine provides relief in severer grades of pain, on low codeine dosage, with minimal possibility of side effects. Its use frequently makes unnecessary the use of addicting narcotics. **Contraindications:** Hypersensitivity to any of the components. **Precautions:** As with all phenacetin-containing products excessive or prolonged use should be avoided. **Side effects:** Side effects are uncommon, although nausea, constipation and drowsiness may occur. **Dosage:** Phenaphen No. 2 and No. 3—1 or 2 capsules every 3 to 4 hours as needed; Phenaphen No. 4—1 capsule every 3 to 4 hours as needed. For further details see product literature.



"Current Developments in Obstetrical Anesthesia"

The film "Current Developments in Obstetrical Anesthesia"—a joint endeavor of the American Society of Anesthesiologists and The American College of Obstetricians and Gynecologists—is now available to Fellows. It has been reviewed by the Committee on Obstetric Anesthesia and Analgesia and was shown as a special film colloquium at the 1969 Annual Clinical Meeting. There is an introduction by Otto C. Phillips, MD, Pittsburgh, of the ASA and Duncan E. Reid, MD, of Boston, a Past President of the College.

This film has been divided into five segments: Epidural Anesthesia in Obstetrics, by Frederick W. Hehre, Jr., MD, Yale University; Spinal Anesthesia in Obstetrics, by Sol M. Shnider, MD, University of California Medical Center; General Anesthesia in Obstetrics, by A. H. Giesecke, Jr., MD, University of Texas, Southwestern Medical School; Fetal Scalp Blood Sampling, by Mieczyslaw Finster, MD, Columbia University Medical School; and Neonatal Resuscitation by Bradley E. Smith, University of Miami Medical School.

The entire film is available, or any of the sections may be ordered through the Ayerst film library.

To obtain a copy of the film contact Ideal Pictures (the Ayerst film distributor) at one of the following addresses:

1619 North Cherokee
Hollywood, California

321 West 44th Street
New York, New York

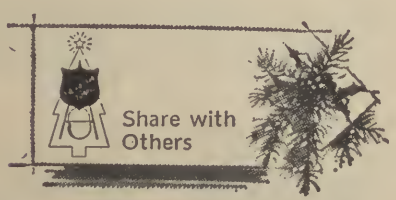
417 North State St.
Chicago, Illinois

102 West 25th Street
Baltimore, Maryland

133 Nassau, N.W.
Atlanta, Georgia

3131 Stemmons Freeway
Dallas, Texas

Help the Salvation Army





count the many reasons **WHY**

the Credit Bureau is your best bet on collection problems

- Our collection department, using data processing, has the personnel and know-how to collect your past-due accounts in an ethical, efficient and effective manner.
- Over 2,000,000 reports in our files are of valuable assistance in effecting collection. Only the Credit Bureau has this advantage.
- Collections never die in the files of the Credit Bureau. Every account becomes part of a credit record for reporting to other businesses—a powerful incentive to prompt payment.
- Affiliation with 3500 other credit bureaus and collection agencies makes collections in all parts of the country fast and efficient.
- Our service costs you not one penny if no money is collected from your patient. Checks, minus commissions, are mailed to you monthly.

Call Mr. Seelig for full details without obligation
752-2260

ESTABLISHED 1882

CREDIT BUREAU OF BALTIMORE, INC.

A subsidiary of Retail Merchants Association of Baltimore, Inc.

Credit Reporting and Collecting

200 W. BALTIMORE ST., BALTIMORE, MD. 21201

THE COMMITTEE ON CONTINUING MEDICAL EDUCATION

of the

UNIVERSITY OF MARYLAND SCHOOL OF MEDICINE

offers a

VISITING TRAINEESHIP IN-SERVICE PROGRAM

(1 TO 4 WEEKS)

Various departments and sub-divisions of the University of Maryland School of Medicine are open to interested physicians through a "Visiting Traineeship In-Service Program" designed to expose the practicing physician to the most current concepts in the practice of medicine, surgery and their various specialties.

This program is highly flexible and designed for each enrollee individually. The enrolled physician will participate in the department's routine scheduled program of Rounds, Clinics and Conferences. No alteration in the departmental routine will be made to formalize the program into a specific postgraduate course. The enrollee will, however, be the guest of the division or department with which he affiliates. Ample allowance of time will be made for collateral reading in the privacy of the library and for attendance at Chief of Service Rounds, Resident Rounds and Grand Rounds, if desired.

Each program is individually designed where possible. Such programs are formulated after a personal interview with the Director, or Assistant Director, of the Committee on Continuing Medical Education, and the Department or Division Head under whose supervision the trainee or enrollee will work. However, if a personal interview is inconvenient because of geographical distance, applications will be considered by appropriate correspondence.

Minimum enrollment is one week (5 days). Longer periods may be arranged with the approval of the Chairman of the Committee on Continuing Medical Education and the Head of the department or division involved.

The Visiting Traineeship In-Service Program allows for cross-disciplinary visiting, or the entire period may be allocated to one specific subject or medical problem. This program, therefore, offers a variety of possibilities that may allow a profitable and rewarding experience.

This program of training is not available during June, July, August and September.

DAVIDGE HALL 522 West Lombard St. **BALTIMORE, MD. 21201**

Classified Advertising

POSITIONS AVAILABLE

GP PARTNERSHIP—Percentage of salary. Retiring in 2-3 years. Two-man office. Not doing hospital work, but open staff hospitals available. Good country. Congenial people. Professional and personal data requested. Send reply to: Box #9, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

RADIOLOGIST—To associate with diagnostic radiologist in office and hospital practice. Board eligible or certified required and Maryland license. Salary to start followed by partnership if mutually satisfactory. Compensation competitive. Reply will be held confidential. Give curriculum vitae in letter to Box #20, c/o JOURNAL, 1211 Cathedral St., Balto., Md. 21201.

LOCUM TENENS DESIRED—Good salary. Practice of IM. Fully equipped office. Call: 437-1655, 233-8434 (Balto.) anytime.

FOR RENT

THREE-ROOM SUITE—Widow of GP has furnished office in home. Private, 1st floor, front and side entrances. Consists of waiting room, consultation and treatment rooms. Air-conditioned. Equipment included, if desired. Call: 465-3340 (Ellicott City).

FOR SALE

EQUIPMENT—From GP's office: Examining table, sterilizers, small refrigerator, infrared lamp, desk, various chairs, tables and cabinets, upright blood pressure machine, scales, nose and throat machine, various surgical instruments. Call: 656-0051 (Bethesda).

CLASSIFIED ADVERTISING

Effective September 1, 1969

$2.00 per line per insertion

Count seven average words to each line. Add one line if box number is desired.

Members of the Medical and Chirurgical Faculty shall be entitled to one complimentary insertion in any twelve-month period. Widows of members shall be entitled to two complimentary insertions for the disposal of the deceased physician's practice or equipment.

MARYLAND STATE MEDICAL JOURNAL
1211 Cathedral St., Baltimore, Md. 21201

M.D.'S NEEDED IN MEDICAL RESEARCH

Satisfaction is relative

We believe that many physicians would find A. H. Robins a satisfying place to work, and Richmond, Virginia a satisfying place to live.

Work: Qualified M.D.'s would be responsible for establishing and maintaining suitable liaison with potential and current clinical investigators of new drugs developed in the A. H. Robins research laboratories. Freedom and willingness to travel up to 25% of time essential.

Live: City, suburban or country living is no more than 15 minutes from our offices. Outstanding universities including a major hospital-medical school complex. Richmond offers excellent cultural and recreational activities. Only 90 minutes to the Blue Ridge mountains or seashore.

We would like to talk to physicians currently engaged in research or in practice, who may have a serious interest in exploring these opportunities. Please forward curriculum vitae in complete confidence to:

T. Burwell Robinson
Director of Personnel
A. H. Robins Company
1407 Cummings Drive
Richmond, Virginia

A·H·ROBINS

An Equal Opportunity Employer

Advertisers in This Issue

A & F Nurses Registry 40
Aids for Hearing, Inc. 14
Arch Laboratories 123
Arundel Federal Savings & Loan Assoc. 48
Baltimore Federal Savings & Loan Assoc. 12
Baltimore Nurses Exchange, Alice Weber 48
Baltimore Oxygen Supply Co., Inc. 96
Belvedere Hotel 102
Bolton Hill Dinner Theatre 92
The Branding Iron Restaurant 92
Brentwood Inn 93
Bridgeforth's Junior Bootery 20
Bryman School 20
Burroughs Wellcome & Co., Inc. 44
Camp, Charis, Kellogg Corset Shop 116
Campbell Soup Company 61
Capital Savings & Loan Assoc. 104
Oscar Caplan & Sons 8
Central Dodge 26
Chesapeake Federal Savings & Loan Assoc. 14
Cobb-Woods Services 128
Cork 'n Bottle Restaurant 93
Credit Bureau of Baltimore, Inc. 131
Doctors Supply Company 20
Edgewood Nursing & Conv. Home .....Cover 2
Eleven East Chase Street Corp. 48
Eutaw Savings Bank 40
The Evangelical Press 112
Executive Consulting Services, Inc. 30
Fedder's Medical Services 8
Fields Pharmacy 128
Franklin Uniform Co. 128
Glenbrook Laboratories 21
The Griffin Agency .....Cover 3
The Gundry Sanitarium 32
Hanna Rug Company 122
Highland Hospital 126
T. C. Horne & Company, Inc. 31
House in the Pines Nursing Homes 121
Hynson, Westcott & Dunning, Inc. 1
Lederle Laboratories 2, 36, 118-119, 123
Eli Lilly & Co. 4
Lucas Bros., Inc. 34
Mead Johnson Laboratories 28-29
Mercantile-Safe Deposit & Trust Co. 37
The Milton Inn 92
F. O. Mitchell & Bro., Inc. 102
Monarch Lincoln Mercury, Inc. 65
Murray-Baumgartner Surg. Instr. Co., Inc. 11
Normandy Farm 34
Northwood Corporation 112
Olney Inn 94
Parke, Davis & Company 64, 117
Chas. Pfizer & Co., Inc., Pfizer Laboratories Division, Terramycin 24-25
Wm. P. Poythress & Co., Inc. 100
T. Rowe Price Growth Stock Fund, Inc. 14
Professional Management Co. 11
Professional Systems & Services 50
Geo. Radebaugh & Sons 121
Raytheon Service Co. 20
Read's Drug Stores 123
A. H. Robins Co. 15-16, 66-67, 122, 129-130, 133
Roche Laboratories .....22-23, 41-43, Cover 4
Russell, Marsh & Kennedy, Inc. 107
Sakura Palace 14
Sandoz Pharmaceuticals 120
Savon Car Leasing 122
Manuel Schwartz Hearing Rehab. 126
G. D. Searle & Co. 62-63
Security Business Services, Inc. 49
Security Savings & Loan 122
Skill Surgical, Inc. 126
Smith, Kline & French Laboratories 90
Special Diet Shop 104
Sterling Lighting Company 116
Strasenburgh Laboratories 97
Stuart 38
Mano Swartz—Furs 8
Tio Pepe Restaurant 92
Tower Ford 18
Towson Ford 49
Towson Telephone Secretaries 126
University of Maryland 132
Van Dyke & Bacon 48
D. Stuart Webb Advertising Services, Inc. 126
White Rice Inn 93
Wyeth Laboratories 98-99, 124-125
Zimmermann's Shoes 8

ARE YOU CONFUSED
about the best Keogh plan
FOR YOU?

As a Physician you can take advantage of the Keogh Act in many ways:

Special Government Bonds

Combination of Life Insurance and Investments

Custodian Account with a Bank

Trust Funds with a Bank

Life Insurance or Annuity Contracts

Mutual Fund Shares

Each plan has its advantages—But which one is best for you depends upon your circumstances.

For Consultation CALL . . .

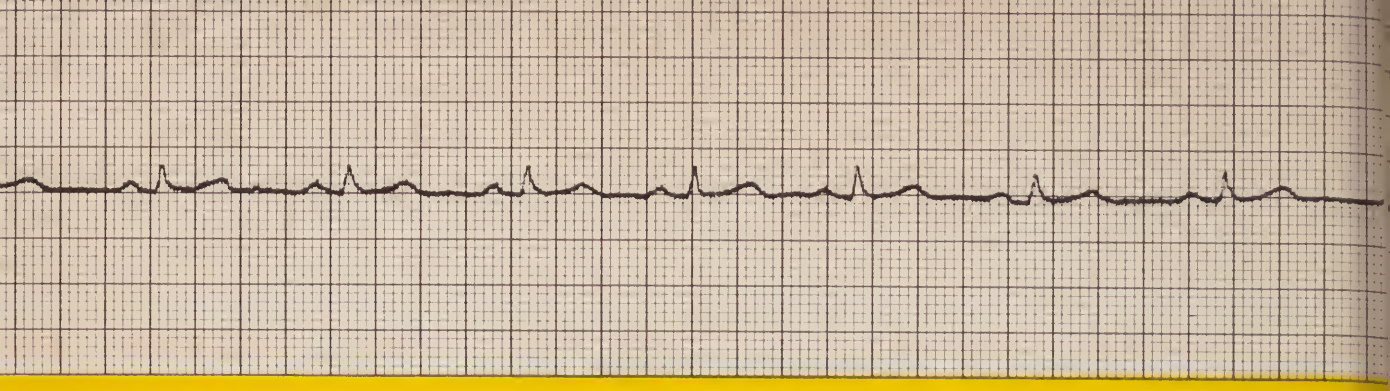
The Griffin Agency

Connecticut Mutual Life INSURANCE COMPANY

17 Light Street

Baltimore, Maryland 21202

752-6740



When disease is ruled out and psychic tension is implicated

Valium® (diazepam) helps relax the patient and relieve his somatic symptoms

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms have occurred following abrupt discontinuance. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation, have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche
LABORATORIES
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110